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ARCHIVES OF DERMATOLOGY.

OCTOBER, 1876.

Original Communications.

Full Length

ON INTERNAL SKIN DISEASES.

BY T. CLIFFORD ALLBUTT, M.A., M.D., CANTAB., F.L.S., ETC.,

Physician to the General Infirmary, Leeds, England, etc.

IT is in no spirit of mere paradox that I venture upon such a title to my present paper as the "Internal Skin Diseases." Certainly I am making use of language a little beside the line of common usage and opinion; and if by so doing I strike the reader's attention, I shall not be sorry; but by diseases of the internal skin I mean certain affections which may strictly be so called, and which have been so neglected or unknown that a new name for them is not without its advantages. To those who have some knowledge of the German tongue my title will seem less peculiar. In that language almost the same name is given to the external and internal teguments—that is to the skin proper—and to the mucous membrane; and if we spoke of the former as the skin and of the latter as the "slime-skin," and if we bore in mind that the two teguments have most natural affinity and a like development, we should be the more ready to remember that they may be subject to similar or identical changes in disease, or to changes only modified by the accidents of their surroundings.

It is the evil of specialism, that such wider views of the relations between distant and superficially unlike changes gain no ground; but, on the whole, specialism is good, in so far, and so far only, as the whole profession assimilates the knowledge gained by specialists, in so far, that is, as the medical public at large will read the Archives of Dermatology. As a specialist, indeed, I have no right to speak. Skin diseases form but a small part of my practice as a physician. Nevertheless, I have always felt an at-

traction to this part of medical science ; as, in skin diseases alone, we can watch closely and can compare the varieties of morbid change, and can combine accurate observations of outside changes with careful inference as to those within. For instance, we can scarcely conceive of ourselves as speaking of all cutaneous inflammations simply as dermatitis. We know that there is an eczema, a psoriasis, an acne, an erysipelas, and many other things which are all dermatitis, and we have accustomed ourselves to expect the higher accuracy. But we are quite content to speak of bronchitis as a sufficiently descriptive term, forgetting that the inflammations of the bronchial skin may be as various in their character as those of the outer tegument. But we cannot see them ; nor does it seem to occur to any one to endeavor to see or distinguish them by the eye of reason. Yet a study of external dermatitis, in all its varieties, may give us fair ground for inference concerning the possible varieties of internal dermatitis, of bronchitis or enteritis. Fortunately we have some help in the visible parts of the mucous membrane ; and the mouth is known to have its varieties of stomatitis, its herpes, its psoriasis, and its parasitic diseases.

It may be well, therefore, for me to prompt inquiry somewhat farther in the same direction.—I say to prompt inquiry ; for I will not pretend now to give a full account, or to attempt a full account, of all that can be included under the present title of my paper. Psoriasis of the tongue, for instance, is sufficiently well known, and so is herpes of the lips and mucous lining of the mouth. This latter, however, is not recognized as fully as it might be. Many persons are terrible martyrs to it ; as it will return, with great obstinacy, many times a year for many years, causing great suffering, and interfering with the power of masticating food. One lady, now under my care, has had this recurrent affection for twenty or thirty years, and her daughter is subject to external psoriasis. Arsenic relieves both patients—the mother a little, and the daughter more. Buccal herpes is, however, as yet in any permanent sense, almost incurable. Another rather common affection is what I believe to be eczema of the bronchial tubes. Now here I may say, that I use the word eczema with a good deal of hesitation, as I am unable to describe the precise characters of the eruptions. After death, it is well known that the character of all moist diseases are much changed, and it is then only that we can examine the state I call bronchial eczema. Moreover, this state is fortunately free from much danger to life, and examinations of it *post mortem* must be rare. The affection of which I speak, however, seems to be eczematous rather than herpetic, or of the character of psoriasis, because it is not so fugitive as herpes, nor is it attended with the evacuation of shreds, as is the case with psoriasis of the colon. Bronchial eczema may be distinguished from common bronchial catarrh partly by its symptoms and partly by its occurrence in persons otherwise known to be liable to such diseases externally. On the other hand, it must be distinguished

from that pure asthma, to which, among other neuroses, persons of a dartrous diathesis are obnoxious. Eczematoid bronchitis causes the following symptoms :—

1. There is much wheezing, and asthmatic oppression and cough.

2. Very variable expectoration, never becoming purulent, generally scanty and frothy, but sometimes more profuse and glairy ; there is occasionally streaky hæmoptysis.

3. The physical signs are confined to the larger tubes, and consist chiefly of sibilant râles.

4. There is little or no tendency to cardiac or other complications.

5. It defies all ordinary treatment, and advances and recedes unaccountably.

6. It is somewhat relievable, but not curable, by change of climate ; and it prevails at all seasons, sometimes even in midsummer. It may recede on the outbreak of external eczema.

7. It occurs at all ages. My youngest patient at present is a child aged two, and my oldest a married lady aged about fifty-eight.

8. The disturbance of general health and nutrition is slight, except in so far this may be due to sleeplessness, etc.

This distressing affection, if rebellious to those general means which improve the secretions, is often ameliorated by arsenic, being about as amenable to that drug as is external eczema. In some cases, the drug answers wonderfully, in other cases less readily. The so-called gouty bronchitis is probably eczematous also ; but, like external gouty eczema, it somewhat differs in development from the dartrous form which I have described above. Gouty bronchitis is too well known to need further distinction. It does not yield to arsenic, but to the remedies appropriate to gout.

Psoriasis, I believe, occurs very rarely if ever in the bronchial tubes, and prefers the tongue and colon. Psoriasis of the colon has been often described under the name of “membranous enteritis”* (Da Costa), “mucous disease”† (Whitehead), “enteritis pellicularis,” “enteritis pseudo-membranacea” (Cruveilhier), and so on.

This disease is marked by attacks of uneasiness, heat, irritability or even of positive pain in the abdomen, with irritability of the bowels, and the evacuation of shreds of membrane, or even of casts of the intestine, though this I have not myself seen. This ailment is recurrent and capricious—coming on for a time, receding or disappearing and again returning, in the way that we observe to be the case in external psoriasis. In some inveterate cases (as in one lately under my care), the condition becomes chronic, if not permanent. During the intervals, the patient is

* Amer. Jour. Med. Sci., Oct. 1871.

† Brit. Med. Jour., Feb. 1871.

quite well. There are no feverish symptoms present at any time. It occurs generally in adults; the youngest patient I have had was a young lady of some twenty years, and the oldest a lady of advanced middle life. Those cases I shall refer to again. It is more common in women, but is by no means confined to that sex. Now, although this affection has been described repeatedly, and was known to Van Swieten if not to Celsus (Whitehead), yet I believe that, in this paper, its true character is first recognized. In most of my cases, it has actually been associated with external psoriasis; but where so associated, it is usually but slightly developed: so that, without inquiry, it may easily be overlooked. Any admission of abdominal uneasiness in the subjects of psoriasis, therefore, should lead to an inspection of the close-stool, when the motions will often be found to contain membranous shreds, and even slimy matter. Such patients, when questioned, will speak of variable and recurrent tumidity and uneasiness in the abdomen. Their bowels are irregular, often constipated, and difficult to manage by aperients, which often gripe or act capriciously. Of remedies, I have found arsenic and pitch the most successful; and I believe that a course of the sulphur waters at Harrogate is likely to answer, in severe cases, as it does in external psoriasis. The lady, Mrs. C——, whose case I promised to refer to again, was the case by which my eyes were first opened to the nature of "membranous enteritis." She has been under my care for many years, for very obstinate external psoriasis, and some time ago she told me (after taking a course of pitch pills, which had been of great benefit to her), that the remedies which answered for her psoriasis succeeded also in removing an irritation of the bowels, to which she had been long subject, but which was thrown into the shade by her more obvious and annoying external malady. On examination, I found that she was decidedly the subject of the so-called membranous enteritis; and I found that, by arsenic or the daily use of thirty grains of pitch, the bowel disorder could be kept under. Finally, I may add that such patients often have buccal eruptions. One of mine has also lingual psoriasis; and in several others I have noted eczematous or herpetic conditions of the mouth.

But my limits warn me that I must not attempt to pursue these interesting inquiries too far, but that my paper must, on this occasion, be rather suggestive than comprehensive. Of the syphilides which occur in the mouth and throat, I need not speak, nor of the scrofulides; unless it be to refer to those painless ulcerations on the back of the pharynx and soft palate, and even on the epiglottis, which are generally covered with foul, yellowish secretion, which are sluggish and ultimately heal with scars or even with much loss of substance, and which are only to be cured by anti-scrofulous treatment.

Did space permit, however, I could lead the reader to think of many affections of the mucous membrane, or internal skin, which are special in their nature and features. Affections of the internal ear are often darts and curable by arsenic; so again

there is a special kind of catarrh of the stomach, attended with gastrodynia and catarrhal vomiting, or pyrosis, which I believe to be eczematous, and which is certainly often cured by arsenic. It was but the other day again that a father brought to me his son aged about eight years, who appeared to suffer from some rectal irritation, and in whose rectum I found, on specular examination, a plentiful crop of minute superficial ulcerations set upon a moist red membrane; which state of things almost declared itself, at a glance, to be eczema. I trust, however, that instances of "internal skin diseases" may now be collected by others, who, by my observations, may be led to watch for such manifestations in their own practice. I need not stay to persuade the reader that such observations are no mere curiosities or strained analogies; on the contrary, if my words be true, a line of promising treatment will be opened up, not only for such intractable diseases as "membranous enteritis," but for many other affections of a slighter or of an equally obstinate kind; and in the classification of such cases, we shall advance to more and more accurate conceptions of those diathetic affinities of diseases, which conceptions lie at the root of successful therapeutics.

~~NEW YORK~~, ENGLAND, August, 1876.

Archives of Dermatology

NOTES ON A RARE APPEARANCE PRESENTED BY THE INITIAL LESION OF SYPHILIS.

BY R. W. TAYLOR, M. D.,

Physician to Charity Hospital, Professor of the Diseases of the Skin in the University of Vermont.

IN the July issue of these Archives, Dr. P. A. Morrow published the history of a case, with commentary, in which certain unusual appearances were presented by the initial syphilitic neoplasm. Having myself been for some years familiar with this form of lesion, which, owing undoubtedly to its rarity, has not been specially described in the text-books, though the general variety to which it belongs is mentioned, I shall now give the results of my observation and study of it, since my conclusions as to its nature are radically different from those advanced by Dr. Morrow. I have thus far seen but three examples of it, while I was attending surgeon to the Class of Venereal and Skin Diseases of the New York Dispensary, where it first attracted my attention, and that of Drs. T. A. McBride and H. Walker, who were then associated with me in the case of the service. The unusual features presented by these cases caused us to watch them with unusual care. In none of my cases was the lesion developed to such an unusual extent as it was in Dr. Morrow's case, which, as will be seen, possesses points of exceptional interest. Before giving rather briefly my own cases, I will quote the clinical history given by Morrow. The patient

was a delicate youth 17 years old, ... "the anterior four-fifths of the glans penis was found to be covered with a glistening, grayish-white coating of leathery consistence, simulating in all its physical characteristics a diphtheritic exudation. This coating was of uniform thickness, raised about two lines above the healthy mucous membrane, and covered the entire surface of the glans, except a narrow zone embracing the corona. The edges of the coating were abruptly raised, and the line of demarcation between its border and the healthy tissue was distinct and unmasked by inflammatory areola. Its appearance was suggestive of a white membranous hood, drawn over the head of the penis, with a slit-like opening for the meatus in front. So evenly and smoothly was it moulded over the glans, that the contour was perfectly preserved. A sensation of a smooth, greasy feel was communicated to the finger passed over its surface. There was absolutely no erosion—its epithelial coat seemed to be continuous with that of the healthy mucous membrane, which limited its circumferential border above. Its base was supple with no trace of induration, its surface moist and glistening with no appreciable secretion. It was intimately adherent, and could not be detached from the tissues which supported it, without leaving a bleeding base." It was painless and indolent, and it had developed some weeks after coitus, some time after which his glans penis had been scratched in a fight. Secondary syphilitic manifestations appeared at the usual time.*

Case 1. N. F. D., 27, sail-maker, first seen May 17, 1871, by Dr. H. Walker, in my absence. On examination, a few days after, I found an oval patch three-quarters by half an inch in area, situated transversely to the axis of the penis, between the corona glandis and meatus. Its surface was of a whitish-grey color, perfectly smooth, elevated to about a thickness of three layers of blotting paper above the normal plane and merged by a rounding, well-defined border into the normal tissue. To the touch a sensation similar to that produced by passing the finger over wet chamois skin was communicated, and when pinched between thumb and forefinger a slight thickening of the tissues was made out. The prepuce was abundant, and not tight, and no abnormal secretion was seen. The lesion had then existed about three weeks, and was accompanied by distinct induration of the ganglia. The date of the infecting coitus was not obtained. Secondary manifestations were noted in June. The patch on the penis subsided slowly until the normal plane was reached, and on its site a coppery-brown pigment spot remained.

Case 2. E. P., ironmonger, Irish, 24 years of age, first seen Oct. 1st, 1873. On each side of the frenum, and involving it, was a well-marked indurated nodule, as clearly defined by its proximal border as if a split pea was placed in the parts, having a raw, shining-red surface, with gummy secretion. Continuous with this nodule, and occupying the under and anterior surface of the glans

* Through the courtesy of Dr. Bronson, I had the opportunity of observing this case.

penis, was a somewhat semicircular patch, which extended into the meatus to the extent of a line. Its surface and appearance was similar in all respects to those of Case No. 1. While, however, the nodule on the frenum produced a secretion, the patch on the glans did not give rise to any. The patch in this case was more of a yellowish than a greyish-white. This man's prepuce was short and generally retracted. On the right side there was a large mass of indurated ganglia, with peri-adenitis, while on the left the ganglia were hard and moderately swollen. This man also presented secondary lesions. Under treatment, the neoplasm upon the penis was absorbed, leaving no trace. The length of the first incubation period was either not obtainable, or was not noted at the time.

Case 3. C. M., American, aged 16, a frame-maker, came to the Dispensary Jan. 28th, 1874. We learned definitely that coitus occurred about December 1st, 1873, and that the patient saw a whitish pimple on glans about January 1st. On examination we found a greyish-white patch, nearly round, having a diameter of half an inch, and situated to the right of the median line, on the glans penis. Though in my notes I have full details as to the general features of this lesion, I may say that it resembled, in every particular, those of the other cases. The inguinal ganglia, at first examination only slightly enlarged, became markedly so at the period of the evolution of secondary manifestations. The treatment in all of these cases was simply the interposition of dry lint. Prepuce in this case was noted as being long but not tight.

When I first saw the lesion I was in doubt as to its character and nature, and from study I have arrived at conclusions, which seem to me to be warranted by our clinical and pathological knowledge. As the initial syphilitic lesion has been so often and carefully studied, I shall not here enter into minute details as to its histological structure, as such would hamper me in my argument, but shall simply term it an infiltration, as that expression will convey my meaning fully. It is well known that this infiltration varies, while in some cases it is so slight or scant and so much spread out, that it is with difficulty appreciable, in others it forms very large nodules. Now this infiltration presents varying features as seen by the eye, most of which are described in the books. In general, tissues thus attacked, become more or less eroded on their surface, owing to various recognizable causes, least so in the chancreous excoriation, and to a greater degree in the indurated nodule. The rule is, then, as judged from the majority of cases, that the epithelial structures over the initial neoplasm shall be thrown off, coming then to be classed as an ulcer, but in some situations, and under some exceptional conditions, this does not occur, and then we have the initial lesion with the epidermis over it in a more or less intact condition. This has been described, but not in an exhaustive manner by Lanceraux as the dry papule, *papule sèche*.

This form is generally observed upon the integument, and I have also seen it upon the mucous surface of a short prepuce. This is in my opinion the condition of the parts in these cases, and if

the epithelial covering had given away we should have had the typical chancrous erosion. To prove this point if a proper opportunity should offer, it would be well to destroy the whitish surface of the lesion either by a solution of potassa or cantharidal collodion, and I venture to predict that a well marked chancrous erosion will result. In these cases the infiltrating tissue of syphilis develops itself in the superficial portions of the membrane of the glans well up to the epithelial covering, involving also the papillæ, being not dense, it does not present the feel of an indurated lesion, but rather that of the chancrous erosion. The whitish color which may even border on a yellowish white, is in my opinion due to two causes; first, to the presence of the new syphilitic cells; second, to the pressure of these upon the superficial capillaries. The same condition may sometimes be seen in the papular syphilide of the negro, and the producing causes are to my mind identical. In an article published in the *American Journal of Dermatology and Syphilography*, April, 1863, I described this lesion and cited an illustrative case. In an exsanguinated condition, the membrane of the glans is nearly white, and if its epidermal covering is stripped off, it will be found to be of a pearly white. To my mind then, this is not a rare lesion, but rather a somewhat rare form of the initial lesion which is thus developed owing to peculiarities of the tissues infiltrated, and to certain conditions of the infiltrating tissues. Let us make a comparison. Let us suppose that the syphilitic virus is deposited upon the glans; the result is a tissue infiltration. In certain cases the amount of infiltration is not copious, as for instance, where it occupies an area of half a square inch, and is superficially deposited; then again we may suppose, that it is copious, and forms a large nodule. In the one case it is not very clearly made out by the touch, in the other, it is distinctly recognizable. Generally we know, that coincidently with the increase of the infiltrative process a necrosis of the covering epithelium occurs, and we have a solution of continuity which in clinical practice we have found to present generally certain appearances by which the nature of the lesion is determined. Now we know that the necrosis is simply an accident, and not an essential part of the process which may indeed run its course without its occurrence. When in certain cases the epithelium does not give way, it is perhaps largely due to the fact of it being unusually dense and tough and perhaps again there may be certain peculiarities of the syphilitic infiltrative process, as its slow development and less compact nature which tend to produce this result. To my mind then this is simply a form of the initial lesion which has been known as the dry papule, and that it is simply and only a modification, owing to the fact of the integrity of the epidermis, of the well known chancrous erosion.

This dry papule is very important in its diagnostic relations. It presents different appearances varying with the tissue upon which it is developed. Upon the integument it may vary in size from that of a pea to an area of an inch, being generally flat, slightly raised, and ending in a well defined, rounding border. In color it

varies from a light pink to a deep coppery red. The epidermal surface may be smooth, may even be traversed by minute lines, or a slight desquamation may be noticed upon it. This form of lesion has been observed several times in experimental inoculation, and I have, though not frequently, met with it in practice. Denuded of its epithelium it would be a slightly indurated excoriation. Then on the mucous membrane of the glans penis it may present the features brought out by these four cases, which show that it may vary largely in size. Then again, I have seen, only twice, to my best recollection, a well marked, indurated nodule of the prepuce, covered with epithelium, which was undergoing slight desquamation. The diameter of these nodules was between half and three quarters of an inch; their surface was rounded, and their color of a deep coppery red.

Such are my studies into the clinical history of the non-eroded form of the initial lesion of syphilis, which I recognize as being far from complete; and I offer them solely with the hope that others will publish their results. From what I have said as to my opinion of the nature of this lesion, it will be seen that I differ with Dr. Morrow in regarding it as a form of the syphilitic chancre which has become complicated with a diphtheritic coating. In other words, I do not regard it as a diphtheritic chancre. In my opinion no comparison exists between the two. The diphtheritic condition of the syphilitic chancre—for we cannot properly say that there is such a distinct lesion as a diphtheritic chancre—is simply and invariably a complication of an eroded syphilitic chancre, as the deposit must of necessity come from an abraded surface. Those observers who have carefully watched the development of the so-called diphtheritic membrane on the initial lesion, as well as on such later lesions as mucous patches, on papules which have first lost their epidermal covering, as well as on certain syphilitic ulcerations, will agree with me as to the truth of this statement. We shall be correct, then, in leaving out of mind this name, as applied to this lesion. If we bear in mind the fact that the initial lesion of syphilis is always an infiltration, which may produce varying physical appearances, in consequence of the peculiarities of the structure upon which it is formed, and of the conditions of its development, we can readily understand that while there may be rare features presented, these are but features, and do not constitute new or rare forms of lesion.

125 East 12th Street, Sept. 18th, 1876.

AMERICAN DERMATOLOGY: AN ANALYSIS OF TEN THOUSAND (10,670) CASES OF CUTANEOUS DISEASE, WITH REFERENCE TO THE SEASONS IN WHICH THEY ARE MOST PREVALENT.

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IN the present article we propose to give a brief outline of the statistics and some of the characteristic features of the more common cutaneous diseases, which present themselves to observers in this part of the United States.

Special attention will be given to the consideration of the relative frequency of these diseases at different seasons of the year. For this purpose, we shall make use of the cases which have come under our observation and treatment in dispensary and hospital practice, during the last ten or twelve years. These diseases have been carefully tabulated for the different months of the year. They present over twenty of the more common varieties of skin diseases. The less frequent and the still rarer forms of cutaneous disease are included in this table, among the miscellaneous. This class will be considered at some future time.

A more thorough knowledge of the class under consideration is of the utmost importance to the general practitioner of medicine, since it includes nearly every variety that is liable to come under his notice, and with the treatment of which he is expected to be more or less familiar. Rare forms of cutaneous disease, sooner or later, find their way to the dermatologist, especially those of a chronic character.

We find, from an examination of our hospital and dispensary records, the histories of between ten and eleven thousand (10,670) cases of cutaneous disease, including dermato-syphilis. Twelve hundred and forty-nine cases are classified at present as miscellaneous. Some of these might be included in the statistical table ; while others are so rare that tabulation, according to the season in which they were observed, would be of no practical value.

Eczema, which is by far the most prevalent of all cutaneous diseases, constitutes nearly one-fourth of all the cases observed, or two thousand six hundred and forty-one. Chronic eczema is much more common in winter, and in spring especially, than in summer. Acute eczema, from various causes, is found at all seasons of the year. The total number of cases observed in the

different seasons is as follows: Summer, 579; autumn, 632; winter, 638; and spring, 792.

Syphilodermata rank next to eczema in number, and are represented in our records by nine hundred and fifty-five cases. Dermato-syphilis was observed much less frequently in autumn and mid-winter than in spring and summer.

Phytodermata, consisting of phytosis vel tinea circinata, tonsurans, favosa, and versicolor, comprise a very large class of cases, numbering altogether from six to seven hundred (642). These diseases are seen more frequently in spring and summer than in autumn and winter. In spring there were one hundred and seventy cases, in summer one hundred and eighty-two, in autumn one hundred and fifty-five, and in winter one hundred and thirty-six cases.

Impetigo was observed in five hundred and seventy-five cases. The larger number by far of these cases appear to have been caused by local irritation on a debilitated skin; while not a few might be denominated impetigo contagiosa. There were one hundred and thirty cases in the spring, one hundred and seven in the summer, one hundred and ninety in autumn, and one hundred and forty-nine in the winter.

Furunculosis occurred five hundred and fifty-seven times; over half of the cases being seen in July, August, and September. This disease is the more or less immediate consequence of excessive perspiration, follicular inflammation, and local irritation of the skin; such as is observed in those who abuse salt water baths during the summer months.

Urticaria numbers four hundred and ninety-five cases; nearly half of them occur in July, August, and September.

Pediculi existed in quantities sufficient to constitute a disease in four hundred and twenty-eight instances. The cases were more numerous in the winter than the summer.

Scabies is represented by four hundred and fourteen cases, about half of which were seen during the three winter months. This parasitic affection is gradually becoming less frequent since the close of our civil war.

Erythema was observed in four hundred and fourteen instances, and was generally most prevalent in the winter and spring. There were thirty-one cases of *E. papulatum*, forty-six of *E. tuberculatum*, thirty-nine of *E. œdematosum*, thirty-five of *E. nodosum*, thirty of *E. pernio*, eleven of *E. intertrigo*, three of *E. annulare*, nine of *E. diffusum extremitatum superiorum*, twenty-three of *E. diffusum extremitatum inferiorum*, eighteen of *E. diffusum et papulatum faciei*, and seven of *E. diffusum natum*. In addition to the above idiopathic varieties, there were eighteen cases of *E. caloricum*. The cases thus classified constitute about two-thirds of the whole number observed. In the remaining third, the form of the erythema was not so typical of the diffuse, papular, tubercular, or annular varieties; and, in some instances, the disease passed through more than one of its elementary forms. Hemorrhage and

gangrene took place in several of the last-mentioned cases. The remarkable development of some of the varieties of erythema in this region, is due in a great measure to the changeable character of our New England climate, both as regards temperature and moisture.

Lichen was observed in four hundred and two cases, nearly one-half of which occurred during the months of July, August, and September, the season of the greatest heat. Excessive perspiration was the exciting cause of this disease, as well as of furunculosis.

Zoster, including the facial and progenital varieties, numbers three hundred and thirty-three cases. It seems to be most prevalent in October and November, and in May and June. In regard to the exciting cause of this eruptive neurosis, most of the cases were clearly traceable to exposure to draughts of cold air, or were consequent upon catarrhal affections of the mucous membranes. From a more complete list, embracing cases from private practice, we present the following statistics of the varieties of this disease:—

Zoster facialis.—*a.* frontalis, 17; *b.* infra-orbitalis, 5; *c.* nasalis, 10; *d.* buccalis, 9; *e.* mentalis, 7; *f.* temporalis, 1; *g.* labialis, 145; *h.* facialis duplex, 8.

There were twenty-six persons having *Z. cervicalis*. The disease was distributed on the different branches of the cervical plexus as follows:—

Zoster Cervicalis.—*a.* Auricularis anterior, in cases 2, 8, and 19,
b. Auricularis posterior, in case 2.
c. Auricularis superior, in cases 4, 6, 8, 10, 16,
 17, 19, and 22.
d. “ inferior, in cases 1, 3, 4, 5, 13, 14,
 18, 19, 21, 23, 24, 25, and 26.
e. Occipitalis major, in cases 2, 5, 6, 7, 8, 11, 13,
 and 14.
f. Supra-clavicularis, in cases 2, 5, 6, 8, 11, 13,
 14, 15, and 20.
g. Facialis, in cases 2, 3, 4, 5, 6, 8, 13, 14, 15,
 16, 19, and 23.
h. Buccalis, in case 8.
i. Cervicalis, in cases 9 and 12*.

<i>Zoster brachialis</i> , . . . 21	<i>Zoster lumbalis</i> . . . 2
“ <i>thoracalis</i> , . . . 74	“ <i>sacralis et femoralis</i> , 14
“ <i>abdominalis</i> . . . 22	“ <i>progenitalis</i> . . . 50

In several of the cases of *Z. facialis*, the disease was recurrent. The same may be said of *Z. progenitalis*. Where large nerve trunks were involved, there was no single instance of a recurrence of this disease. In no case was zoster bi-lateral on the trunk or

* In this case the eruption was bi-lateral.

lower extremities. In all of the larger varieties of zoster, the eruption, as a rule, was preceded by neuralgia, in the region to be affected, often from three to five days. In some cases, the pain continued several weeks, and even months, after the disappearance of the eruption. Formication and other disagreeable sensations frequently succeed the pain.

Acne disseminata and *A. rosacea vel gutta rosea* have been tabulated together, although quite distinct diseases, as regards their causes and clinical histories. There were two hundred and ninety-seven cases in all. These diseases were most frequently observed in spring and early summer. Acne was seen in young persons only; while *gutta rosea* seldom occurred in individuals under thirty years of age.

Psoriasis occurred two hundred and six times, and was observed most frequently in winter and spring. Many of the patients had been subject to aggravation of the disease at these seasons. In several instances, the patients were the subjects of constitutional syphilis. In one case, rupia crusts were developed upon patches of psoriasis on the thorax and abdomen.

Erysipelas of the face was observed in two hundred and three (203) instances. Fifty-seven cases were seen during the six months from June to November inclusive; while one hundred and forty-six cases, or nearly three-fourths of the whole number, presented themselves during the winter and spring. Exposure of the face to the wind was the exciting cause, in many of the cases. Persons of intemperate habits were the most frequent subjects of this disease. Idiopathic erysipelas, on the covered portions of the body, was very seldom seen as an independent disease.

Pruritus cutaneus was most frequent in winter and spring, and was noticed in two hundred and three instances.

Hyperidrosis generalis aut partialis, occurred in one hundred and sixty-seven (167) cases. More than half (93) of the cases were observed during the months of July and August.

Rubeola and scarlatina were observed for the most part in dispensary practice. They are rarely seen at our hospital clinic, except in their lighter forms and incipient stages. One hundred and forty cases of rubeola, and one hundred and twenty cases of scarlatina, are recorded. Eighty-two cases of rubeola were seen during May, June, and July; thirty-five in April, twelve in March, five in February, three cases each in November and December, one in January; and no cases in August, September, and October. Scarlatina was the least frequent in the summer months, and most prevalent during the winter and spring. Only one-sixth of all the cases were noticed during the summer.

There were one hundred and four cases of alopecia from all causes. These cases were most frequently observed in the spring and summer.

There were seventy cases of hemorrhage into the skin. They were about twice as numerous in spring and summer as in autumn and winter.

There were fifty-five cases of lupus. Two-thirds of the cases presented themselves during the three winter and three summer months.

TABLE OF THE MORE COMMON CUTANEOUS DISEASES IN 10,670 CASES.

	May.	June.	July.	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	March.	April.	Total
Acne.....	29	28	23	21	19	25	22	21	38	20	19	32	297
Alopecia.....	10	12	9	10	12	9	5	5	11	6	1	14	104
Eczema.....	263	215	197	167	202	229	201	204	229	205	267	262	2,641
Erysipelas.....	24	15	16	8	4	8	6	25	27	23	22	25	203
Erythema.....	32	40	40	33	26	22	36	41	36	33	34	41	414
Furunculosis.....	27	25	113	150	53	43	27	33	25	26	18	17	557
Hemorrhagiæ.....	7	10	8	7	7	5	2	4	3	5	6	6	70
Hyperidrosis.....	13	12	50	43	16	6	2	1	7	2	9	6	167
Impetigo.....	38	19	27	61	33	72	85	50	63	36	41	51	575
Lichen.....	36	17	76	75	47	48	28	21	13	5	11	25	402
Lupus.....	8	5	6	3	2	6	2	4	9	6	1	3	55
Pediculi.....	35	27	20	32	28	35	55	37	52	32	26	40	428
Phytodermata.....	54	50	62	70	52	57	45	36	54	46	47	69	642
Pruritus.....	21	9	18	8	11	25	15	17	28	9	20	22	203
Psoriasis.....	24	17	15	4	18	20	18	12	28	17	20	13	206
Rubeola.....	42	26	14	—	—	—	—	3	1	5	12	34	140
Scabies.....	27	20	18	15	19	24	43	37	78	56	55	22	414
Scarlatina.....	7	18	10	6	—	5	27	15	6	14	14	8	120
Syphilodermata.....	100	84	98	91	69	64	75	59	81	72	104	61	955
Urticaria.....	29	42	58	102	84	48	20	15	29	15	18	35	495
Zoster.....	32	34	24	27	27	36	33	31	24	20	16	29	333
Miscellaneous.....	151	111	99	74	68	108	103	112	108	88	93	134	1,249
Total..	1,009	836	1,010	1,007	797	895	852	772	947	741	855	949	10,670

ON THE QUESTION OF THE CONTAGIOUSNESS OF VENEREAL WARTS, THE SO-CALLED CONDYLOMATA ACUMINATA.

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OPINIONS upon the contagiousness of the so-called condylomata acuminata are divided. Most authors incline to the opinion that they are *not contagious*. I, myself, came to the positive conclusion of the contagiousness of these growths, several years ago, and founded my opinion upon the following facts. I was convinced on the one side by clinical experience, and especially by one case, reported by me in "Schmidt's Jahrbücher," where it is stated, that a child contracted these growths, from having used, repeatedly, the same chamber with its nurse, the genitals of the nurse being at the time affected with innumerable condylomata; it also having been proved that she was non-syphilitic. Here arises a question of indirect transmission. On the other hand, we must bear in mind the

positive results obtained through vaccinations from these condylomata, by Dr. Kranz and Prof. Lindwunn, in the clinic of the latter. (Deutsches Archiv. f. Klin. Med., 1866, Bd. II. p. 79.)

The late Prof. Petters, of Prague (Vierteljahresschrift f. Dermatologie u. Syphilis, 1875, p. 255), who taught for years and in different works, the non-contagiousness of condylomata acuminata never became reconciled to my views, in relation to this subject, nor to the proofs and evidences furnished by others; inasmuch as he regarded the clinical testimony as not to be depended upon and the vaccination experiments as untrustworthy. According to Petters (ibid, p. 263), "the experiments in Lindwurm's clinic failed, in two particulars, which, in all thorough investigations, are indispensable, as follows:—

1st. The perfectly healthy or normal condition of the portion of the skin used for the experiment.

2d. The withholding of every means which is capable of producing similar results to those striven for in the experiments, because, by leaving out of consideration both these points, in case of the success of such an experiment, it would be difficult or impossible to prove whether the success were not to be attributed to one of these unnoticed conditions."

Petters brought to his support the opinion of Hebra, who regarded venereal warts as non-contagious, and the experiments of Kranz as unreliable. I will here add further the views of several writers upon this question. Ricord looks unfavorably upon the theory of contagiousness. Prof. Reder, of Vienna, considers the question of infection as highly probable. According to Prof. Geigel, of Würzburg, condylomata acuminata appear certainly, in many cases, to be communicated through contagion. Zeissl, who regards them as local growths, which may be removed through local measures, acknowledges their infectiousness. He, with others, refers to a case of Sir Astley Cooper's, whose assistant, during the extirpation of a large condylomatous formation, was wounded in the vicinity of the finger nail, and, as a result, there was developed, at the point of injury, a growth of condylomata acuminata. Prof. Isidor Neumann, of Vienna, in his excellent work on skin diseases, does not deny the possibility of contagiousness, but still considers it an open question. Prof. Lebert, on the contrary, in his work, and also in his treatise on gonorrhœa (Handbuch der speciellen Pathologie und Therapie, von Ziemssen), is of the opinion that they are *positively not contagious*. As the writer was drawn into this controversy by Petters, he holds it to be his duty not to leave unanswered the expressed opinions of this able observer; especially so, as the opinions of most authors, as we have seen, are very contradictory. If, therefore, in spite of the positive results of inoculation with condylomata acuminata and their secretions, the majority of authors express themselves against such contagiousness, we cannot, of course, consider the question as definitely settled. For these reasons, I instituted a series of experiments, six in number, exclusively for myself, to test the truth

of this question; and in conducting the same I avoided those errors which Petters and Hebra found in the experiments of Kranz and Lindwurm, thus making it impossible for any one to object to their thoroughness. I selected a portion of the skin, the furthest possibly removed from the then existing condylomata, in order, by so doing, to avoid the objection that this inoculation was in the vicinity of the disease, which, if such were the case, would render its success much more probable, through unknown circumstances existing probably in the parts before the operation.

The frequent occurrence of condylomata acuminata on the genitals shows that this locality is especially favorable for their development. Their rarer appearance elsewhere is an indication that, in other places, the soil and other requirements for their development are not so favorable. If we do not acknowledge the contagiousness of venereal warts by means of which we seek to explain, to a certain extent, their more frequent occurrence on the genitals, there remains but to assume that the genitals, owing to various secretions and unrecognized conditions, are more favorable localities, where these growths, through unknown causes and in spite of such therapeutical measures as sometimes may prevent their increase, are more easily developed than on other portions of the skin. If we therefore select other localities for the purpose of transmitting condylomata acuminata, we will find at once, at every other such point, unfavorable conditions for their successful transplantation or inoculation. The negative result of a few experiments cannot, therefore, be regarded as conclusive, because a proper soil is necessary for the complete growth of an inoculated or transplanted disease. The locality selected must at least have a normal circulation, together with some moisture. A portion of the skin, rendered hyperæmic and kept artificially moist, would, of course, be more favorable; such a point, however, prepared in this manner, would detract from the value of the experiment. If the point chosen for the procedure is irritated by scratching and rubbing, by means of a scalpel, etc., as was done by Petters, in order to induce, if possible, artificial condylomata acuminata (wherein Petters obtained negative results), or if, in order to render the soil a more favorable one, we should employ fomentations of water or salt water before the inoculation, the value of the experiment could again be contested (in case of its possible success); because then it could be claimed that the condylomata were induced, not by inoculation, but by local irritation.

In order to obtain certain proofs of the transmissibility of condylomata acuminata by means of an operation, all measures of a preparatory character should be avoided, for although the locality selected may be perfectly normal, still, at the same time, it may be unfavorable for such a trial.

If experiments, made in the manner which I have indicated yield negative results, this would still not prove their non-inoculability, as it would be no evidence that repeated inoculations would always produce a like result, and I grant that a successful result

might possibly be brought about, at a point unsuited to their development.

Clinically speaking, it is proven that condylomata acuminata have been observed upon all portions of the skin and mucous membrane ; so that, regarding it in this light, the necessary conditions for their growth may be found in all localities (independently of syphilis or gonorrhœa), although to a much less extent than on the genitals.

The study of their development does not controvert, either pathologically or anatomically, the reliability of the experiments undertaken by me. Venereal warts develop, as we have already learned, in the sub-cutaneous and sub-mucous cellular tissue ; grow readily in the cellular tissue of the papillæ of the skin ; are therefore, more frequently observed at those points, in which, as on the genitals, numerous papillæ are found ; they are, however, by no means confined to the papillæ, as they are found on portions of the skin where these do not exist.

Clinically, anatomically and pathologically, there is nothing opposed to the possibility of a successful inoculation, if such be made upon the upper arm of the individual. It is unimportant for the deciding of the question of transmissibility, whether we operate upon syphilitic or non-syphilitic persons, as condylomata-acuminata are found upon non-syphilitic persons and it has been proven, that neither by clinical, pathological, nor anatomical investigations have they anything in common with syphilis, although they are frequently met with on the cicatrices of syphilitic ulcers, less frequently upon the edges and cicatrices of other ulcers about the genitals not dependent upon gonorrhœa. Therefore should it be tested upon one already infected with syphilis, the result would be equally trustworthy.

EXPERIMENT I. A man aged 26, in good health, had contracted an indurated chancre, which was followed by the usual symptoms of syphilis. Eight weeks after infection the ulcer was healed, the induration had almost entirely disappeared ; upon the genitals, which were kept constantly clean, there was nothing abnormal worthy of notice. The inguinal glands became swollen. The patient observed after the lapse of four weeks, what was supposed to be a condyloma acuminatum on the cicatrix of the chancre in the corona glandis, which it eventually proved to be. It was treated for four weeks with great cleanliness, and increased to the size of three millimetres ; there were also developed, simultaneously, several others in the immediate vicinity of the first, as also upon the dorsal surface of the glans. The largest was removed and its base immediately enclosed within the edges of an incision upon the upper arm ; it was then covered with waxed paper and over this adhesive plaster. After two days the wound was encrusted, the dried remains of the condyloma were securely united to the crust, and in the immediate vicinity of the incision there was slight inflammation. A week after the operation the crust had fallen off and the wound was entirely healed. No condyloma was developed on the arm. Upon the same patient

EXPERIMENT II was tried in which a condyloma which had developed in the meantime, together with another smaller one, were placed in an incision on the other upper arm; the result was the same as in the previous experiment, negative. By this time, the condylomata acuminata on the penis had been removed by means of tannin and corrosive sublimate, and for a period of four months and a half they were entirely absent. At this time there appeared upon the site of a previous condyloma a new one, which, forming

EXPERIMENT III, was transplanted as before on the upper arm, again with a negative result. No symptoms of syphilis were present at the time, nor had this patient ever contracted gonorrhœa. According to his statement he had had no sexual intercourse, since he first contracted the chancre.

EXPERIMENT IV. In a healthy girl, aged 10, who had never had syphilis, I found upon the left side of the lower jaw, arising from a portion of the gum which had become detached from two molars, a group of condylomata acuminata in the form of a cockscomb. A portion of this growth was removed and inoculated on the upper arm of a man, who two years previously had been treated by the writer for syphilis. This inoculation was made precisely like those above-mentioned. The result was still negative; the course was the same as in the first experiments. Up to the time of this report no indications of syphilis were apparent, although he was not considered entirely cured.

EXPERIMENT V. In a fresh incision upon the other upper arm of the same patient, were placed condylomata which had just been removed from a woman, affected five months with severe syphilis. She was suffering from leucorrhœa and upon the genitals were found innumerable condylomata acuminata of which some were as large as beans and whose development I had been carefully observing for two months previously. The inoculation of one of these resulted negatively as before.

EXPERIMENT VI. From the woman just mentioned another condyloma was removed and inoculated upon her upper arm with a result exactly similar.

In relation to the therapeutical side of the question I will only add, that in these syphilitic patients affected with condylomata acuminata neither anti-syphilitic nor local treatment was administered. The withholding, therefore of all outside influences was highly favorable to the results of these experiments. It is known, that they being localized growths, yield to local measures; and that while syphilitic symptoms disappear under anti-syphilitic treatment such venereal warts as may be present at the same time increase only the more rapidly. It has however, been observed, that isolated condylomata may disappear together with syphilitic symptoms during a course of inunction without any local treatment whatsoever. Without wholly disregarding such a rare circumstance, as pointing apparently to the syphilitic nature of venereal warts, it should not be forgotten that in conducting these inocula-

tions the persons upon whom they are made should not be subjected to a mercurial course. The occasional shrivelling in disappearance of a condyloma acuminatum during a course of inunction, I would explain in the following manner: If one or more condylomata develop upon the cicatrix of a recent syphilitic growth, or even directly upon such a growth itself, they would very readily become shrivelled, should their specific base or soil be *quickly* made to disappear, through the agency of a mercurial course. We are familiar with the fact, that in favorable cases, specific formations through the influence of mercury are very quickly removed, being, as it is called, absorbed. This absorption takes place for the reason, that the cells of syphilitic products are more readily influenced by mercury than those of the normal tissue. The cell activity is increased, their contents degenerate and they disappear in a fatty metamorphosis of tissue. If this process takes place very rapidly, it is easy to conceive, how, owing to the destruction of their developmental soil, isolated warts accidentally situated upon abnormal tissue, must shrivel and disappear; because, in this particular instance, they can derive no further nourishment; while, at the same time in other localities where this process is not so rapidly carried on or does not occur, the condylomata grow on uninfluenced. To the experienced practitioner these facts may often come under observation. The so-called condylomata lata, upon which, under certain circumstances, condylomata acuminata may have their seat, become swollen under the influence of a mercurial treatment, more spongy and irregular in outline, softer and finally become degenerated and stained a whitish blue color, until at last they disappear. Such a termination may be most easily observed in the opaline, pearly, or chalk colored spots on the mucous membrane of the mouth and tongue. These white spots are the fatty metamorphosis common to syphilitic lesions; they may however arise sometimes from a non-syphilitic source.

After all our investigation and experiments, we are forced to say that the question of the transmissibility or inoculability of the condylomata acuminata is still undecided. In conclusion we may add that the subject has a certain importance in a medico-legal point of view. A physician may be asked if, from the state of the genitals of two persons at a given time anything could be conclusively determined in regard to coitus and infection. In case only condylomata acuminata were found upon both persons he could only reply, in accordance with our present views, that from this condition of the genitals, he was not in a position to give a positive answer.

NOTES ON THE LOCAL TREATMENT OF CERTAIN DISEASES OF THE SKIN.*

BY L. DUNCAN BULKLEY, A. M., M. D.,

Physician to the Skin Department, Demilt Dispensary, New York, etc.

IV. *Chloasma*.—It has been not at all uncommon to call the fawn-colored parasitic eruption found on the breast (also on other parts, more commonly the back), by the name *chloasma*, known also as liver spots; this eruption will be described later on under the proper term, *tinea versicolor*, called likewise, *pityriasis versicolor*. The disease here spoken of as *chloasma* is quite a different affair, it being due to an abnormal pigmentation in the rete Malpighii and is in no wise associated with, or related to that before alluded to and caused by the vegetable parasite. *Chloasma* consists of the brownish discolorations, of irregular sized and shaped patches, seated principally upon the face; in the female it occurs more commonly upon the forehead and about the mouth and chin, in the male upon the cheeks, but also on the forehead and chin less often. The surface is smooth, no desquamation, the edges are generally pretty sharply defined. It is hardly necessary to say that this eruption is in no way connected with syphilis, and may be entirely removed by local measures. I have found the following mixtures very successful: *R. Hydrarg. Bi-chlor. gr. vj. Acid. Acetici Dil. ℥ii; Boracis Pulv, ℥ii; Aquæ Rosæ, ℥iv; M. ft. lotio*, to be applied night and morning. At first this may be gently brushed over the affected parts, which may afterwards be rubbed well with it, with flannel as hard as can be borne without causing too much irritation: if the skin becomes too scaly, arrest the treatment for a day or so and cover the face with sweet cream. Or the following prescription is oftentimes serviceable: *R. Hydrarg. Bi-chlor gr. x; Ammon. Mur. ℥ss; Misturæ Amygdalæ Amar. ℥iv. M. ft. lotio*. This latter is stronger and is to be used with more care, and its strength even augmented. The following ointment is moderately efficacious: *R. Bismuthi Sub-nit. ℥i; Ung. Hyd. precip. alb. ℥iii; Ung. Aquæ Ros. 3v. M.*

These discolorations of *chloasma* will, however, often return, and we can only expect palliation while the cause remains.

V. *Clavus*.—Although corns may seem to be somewhat without

* These "notes," are intended to report for the use of the general practitioner, the local measures in common use by the writer in the treatment of diseases of the skin, and which may safely be employed: it is not intended that they shall be exhaustive nor that these measures are recommended to the exclusion of constitutional treatment: the formulæ are not claimed as original, though some of them may be. These "notes" are continued from pages 212 and 307 of Vol. II.

the practice of the regular physician, and have been often left to the care of those who are generally uneducated but possess some practical skill in their manipulation, it is needless to say that the general practitioner should be able to give proper advice for them, and that the careless neglect of these often distressing deformities on the part of the profession has led to the extravagant claims of corn doctors, and in a measure to their good success.

The first thing in the treatment of soft or hard corns is to insist upon the use of proper coverings for the feet: the stockings should fit snugly and not be too large, as their wrinkles may give trouble. It is very advisable that patients with a tendency to tender feet should have at least two pairs of shoes of the same kind, that is, several thick and several thin ones, so that they can be worn, as occasion requires, on alternate days; never wearing the same boot or shoe on two successive days, better even to have three pairs with which to alternate. By this means the irritation and pressure caused by one pair is allowed to subside while wearing others, which commonly bind in a little different place. Shoes should not be too large, but fit snugly, the soles should be rather wide than narrow, the toe ends always square and not pointed, and they should always be abundantly long, so that the toes will never strike the end: if these simple and homely precautions are neglected it will be hardly possible to render the sufferer effective and permanent service.

The most serviceable local affection I have used is the unguentum diachyli of the Germans, worn continually, until the corn has disappeared: in addition to the soaking and paring, scraping or rasping, all of which must be done with some caution, a strong solution of caustic potassa, grs. xv., xxx. vel. lx. ad ℥ i. will assist materially in removing the hardened epidermal layers. We consider it wise to recommend the use of the rings of soft felt sold in the shops, until healthy cuticle is re-formed.

VI. *Dermatitis*.—The local treatment of dermatitis must vary greatly with the case, and as it is a purely local affair its topical treatment is of importance. Poultices should very rarely be employed, although often they seem to be indicated in dermatitis, unless pus has already formed, whose evacuation can be thus accelerated. As is known, excluding the specific dermatites, erysipelas, eczema, etc. inflammations of the skin come under one of three heads, dermatitis traumatica, venenata, and calorica. The *dermatitis traumatica* generally owns some palpable exciting cause upon whose removal the inflammatory action ceases and the skin returns to its normal state with a very slight assistance, whether from the mild action of such bland agents as cosmoline, cold cream, etc., or such remedies to meet inflammation as are familiar to all. *Dermatitis venenata*, or inflammation due to poisonous agents, as especially that of the rhus toxicodendron, yield very well to the continued application of the ordinary black-wash, of calomel and lime-water, during the day, and at night an ointment with carbolic acid (grs. x,xx ad ℥ i) with a little calomel (℥ss);

or an ointment of quinine, a drachm to the ounce. For these sometimes the carron-oil, equal parts of lime-water and oil, is the best application. We need hardly enter into the local treatment of the third variety, *dermatitis calorica*, from the effects of heat and cold, as nothing can be here advanced which is not contained in the proper text books.

The local treatment of chronic dermatitis, where the acute process has resulted in cell infiltration is quite different; here stimulation, often quite active, is necessary, and the same measures now to be detailed for chronic eczema are of service.

VII. *Eczema*.—While we believe eczema to be a manifestation of constitutional disorder, and not a local disease of the skin, we cannot but recognize that local causes play a very important part in its causation, and that proper local treatment is well nigh essential to its cure: the succeeding remarks are to be thus understood. It will be hardly possible within the limits of such "Notes" as the present, to detail the local treatment suited to each and every case of eczema, but we will endeavour to give such indications for the use of each remedy as can be applied to other states than those specified.

Commencing with infantile eczema; the ordinary oxide of zinc ointment of the Pharmacopœia, eighty grains to the ounce, or even a drachm to the ounce, will be found too stimulating for the delicate skins of very many young infants, and twenty or thirty grains to the ounce will be found to succeed much better. In the Dispensatory we have it made with lard, this latter I never use in ointments, preferring always the rose ointment, unguentum aquæ rosæ or cosmoline. Bismuth sub-nitrate may be used with advantage in the same strength, and will often succeed when zinc fails; very frequently great service will be rendered by the addition of a very small proportion of the ordinary tar ointment, say one or two drachms in the ounce, combined with a little zinc, bismuth or calomel. A very important point in the treatment of infantile eczema, and indeed all eczema, which does not yet appear to be understood or at least practised by the profession at large, is the necessity of avoiding the application of water; I so frequently see cases of eczema of the head and face where very proper treatment has been employed, except that the part has been continually washed, which would get well very promptly under the continued application of a proper ointment and the avoidance of water.

On several former occasions I have spoken very strongly in regard to another error in dermatological practice, and feel that it is necessary to mention it again in this connection, and that is the continued and repeated use of poultices in eczema, especially on the heads of children. I believe that it is well nigh impossible to cure the disease there under continued poulticing, though occasionally a single poultice will be needed to remove a thick incrustation, after which other treatment should be employed.

After the acute stage is passed, and the eczema is more or less localized, as on the cheeks, the following will be found of much

service : *R.* Olei Cadini 3 ss ; Ung. Hydrarg. Oxidi Rubri, 3 i ; Ung. Aquæ Rosæ. 3 vij. *M.* It is also quite proper to use a weak ointment of white precipitate on limited patches of eczema, when not too acute, thus : *R.* Ung. Hydrarg. Ammon. 3 i-3 ij ; Ung. Aquæ Rosæ ad 3 i. *M.* The oil of cade pure or mixed with an equal quantity, more or less, of almond oil, will sometimes answer the very best purposes, this to be rubbed on with the finger. On the eczema about the body, where chafing can occur, especially about the buttocks and thighs, powders often do much more good, thus : dry the part carefully and without friction with a soft linen cloth, then dust it thoroughly with a powder such as the following : *R.* Zinci Oxidi 3 j ; Pulv. Amyli 3 ii : *M.* or, *R.* Bismuth. Sub-nit., 3 ij ; Pulv. Lycopodii, 3 ij ; *M.* powdered camphor may be added, in the proportion of from ten to thirty grains to the ounce, if there is much itching. Very finely prepared chalk or carbonate of magnesia are also very good for this dusting. The effect of these is much increased by taking old linen and dusting it thoroughly with the powder and applying it closely to the diseased surface ; I have thought that in eczema on surfaces touching each other, as about the groins, in the neck, etc., more benefit has been derived when the rags used have been previously scorched on a hot stove.

When it can be borne, the compound tincture of green soap of Hebra [*R.* Olei Cadini, Saponis Viridis, Alcohol aa 3 i. *M.* et filtra] will yield good results in the eczema of children, but causes considerable pain when first applied; it will, however, arrest the itching and thus affords much relief. It is to be applied with a muslin rag and rubbed over the diseased surface, which must then be covered immediately with an ointment spread on cloth, the surface to be kept covered all the time; the tar wash to be applied once or twice daily.

Baths are of great service in the treatment of infantile eczema, and as in the ordinary care of children much use is generally made of water, it is important that the practitioner should direct in regard to this. Baths given to children vary so greatly in the amount of water used, according to the age of the child and convenience or fancy of the attendants, that it is necessary, of course, in prescribing a medication to state the quantity of water to be employed, or to give a relative measure. Thus, I frequently give the following prescription : *R.* Potass. Carbonat. 3 iij ; Sodæ Carbonat. 3 ij ; Boracis Pulv. 3 j ; *M.* and direct that a heaping teaspoonful of it shall be used for every two quarts of water ; or two teaspoonfuls may be put in if the itching is not relieved, and if it appears to suit the skin. It will be far better to add some starch to the bath as well, thus, if it is convenient to boil the starch for each bath, I direct that one large tablespoonful of dry starch shall be boiled in a little water and added for each two quarts of water, or, a drachm or two of powdered starch for each two quarts of fluid may be stirred into the bath. Of course no soap is to be used in these baths.

Most nurses will wash the child in a small quantity of water, unless directed otherwise ; I think it important to use sufficient

water to cover all the diseased parts, when practicable, the head excepted, and to allow the little patient to soak in the bath for from five to ten minutes ; the temperature of the water should be between 85° and 92° Fahrenheit, according to the season and the patient. After the bath some care must be exercised in drying the surfaces without friction, by means of soft, warmed linen cloths, after which the local application which has been selected, is to be made ; *eczematous surfaces should never be left unprotected after a bath, or after the use of a wash* ; it is often advisable to coat lightly the rest of the body with some such substance as the glycerite of starch or cosmoline. I not infrequently direct that a portion of the bath-water, when prepared for use and before being used, shall be taken out and kept to wash the diseased parts with, if required, during the day. It not infrequently happens that baths are not well borne by children, and instead of having a soothing effect they seem to aggravate the itching and burning, and the child has a more restless night after taking one, than when not. They may then be tried during the daytime, instead of at night, as commonly used, and the ingredients may be changed. The alkali is perhaps too strong, or more starch is required ; acetate of potassa may then be tried two or three drachms to the quart or so of water, and decoction of bran may be substituted for the starch ; or gelatin ; I have sometimes used glycerine, two or three teaspoonsful to the quart, instead of the starch.

(TO BE CONTINUED.)

Clinical Reports.

I.—*An unusual form of bullous eruption.** BY GEO. HENRY FOX, M. D., New York.

Henry B. a young man aged 15, came to me in July, 1875, with a bullous eruption seated principally upon the extensor surface of the forearms. The bullæ were either single and surrounded by a narrow red areola or formed confluent patches upon a hyperæmic base. They were mostly pea-sized and showed no tendency to the formation of clusters, the confluent patches not being grouped, but of irregular outline, with numerous isolated bullæ scattered near them. A few bullæ were of hazel-nut size, and one near the elbow was as large as a walnut and like the others quite full and tense. A few small bullæ appeared upon flexor surface of forearms and upon backs of hands and one or two excoriated vesicles were to be seen above the elbow. No other portion of the body was affected.

The eruption had begun ten days before, vesicles forming at the outset, and the areola appearing when these had attained the size of a small pea. No marked itching. Slight if any general symptoms. Epistaxis. When seen by me, patient claimed to be well, but was pallid and had an anxious expression of countenance plainly showing that he was "run down" in health. The eruption at this time (10th day) had evidently just passed the height, the bullæ were becoming flatter, their contents somewhat turbid and the epidermis over the confluent patches was wrinkled from absorption of serum. The arms felt stiff and sore. From the bullæ accidentally ruptured or purposely opened slightly alkaline serum was obtained. From the smaller bullæ a yellowish gummy fluid exuded forming on some a very thin honey-like crust. Upon the seat of the eruption in general, however, no crust formation took place, and within two weeks from its beginning nothing revealed the location of the bullæ and confluent patches save bright red spots of denuded skin with a margin of exfoliating epidermis.

The vesicles or bullæ did not appear in successive crops,

* This case is represented as No. 5 in my "Photographic Illustrations of Skin Diseases."

although two small ones came on the back of the hand when the eruption had nearly run its course, which it did within a space of three weeks, and apparently irrespective of treatment. Iron and quinine was given internally and powdered starch applied locally as an absorbent.

Patient stated that he had poisoned his arms in the woods about three years before, and suffered four days from a red itchy eruption, but with no blebs. He had since poisoned his legs in a similar manner. His father had been subject to epilepsy, but patient had never suffered from any nervous affection himself, nor from syphilis, nor from any skin troubles besides those mentioned.

II.—*Clinical Conversations on Diseases of the Skin.** BY THE EDITOR. Reported by Robert Campbell, M. D., Clinical Assistant.

CASE I. *Psoriasis punctata*. This man, aged 32, exhibits an eruption, which, while it should offer no difficulty in diagnosis, might on superficial observation perplex one not familiar with the disease in all its features. Psoriasis is very rightly associated in the minds of most physicians with circular patches of diseased tissue, reddened bases with an abundance of silvery imbricated scales, readily detached, the eruption being most marked upon the elbows and knees; the patches are usually thought of as of good size, from an inch upward in diameter. The eruption on this man, as you see, has spared the knees entirely, the elbows being very slightly affected, while a large share of the body is thickly sprinkled with these small reddish dots of various sizes, most of them not larger in diameter than that of a split pea, the largest being hardly as large as one's thumb-nail; the smallest hardly larger than a large pin-head. Moreover most of them present very little of scale. But on scraping each of these little spots you get a small amount of the same silvery scale obtainable from larger patches, and on further removing this we find at last a little pellicle which slips off, and beneath we have the exposed corium which bleeds with slight irritation.

Now what are the features distinguishing this case to be psoriasis, for this disease may be confounded with the scaly syphiloderma, chronic scaly eczema, tinea circinata, and possibly, (though hardly in this country,) with lupus erythematosus.

Syphilis is excluded by the absence of specific history and by the fact that he has had the eruption on several occasions, dating back five years. A syphilitic eruption never repeats itself in exactly the same form. But the appearance of the eruption itself is quite characteristic to the practised eye; you will never get such silvery scales on scraping a syphilitic eruption, nor just this bleeding state of the corium on scraping them off forcibly. The size of the single spots varies greatly, from these minute, almost pin-head specks to these others, half or three-quarters of an inch in diameter

*Cases shown and remarks made to private classes at the Demilt Dispensary, New York.

on the body ; those of syphilis are more uniform in size and medium between the extremes, they are more elevated than the flat squamous syphiloderm, less so than the later variety of tubercular character. The color is that of psoriasis and not of syphilis, the difference I cannot express in words truly, (for the historic copper-colored hue of syphilitic eruptions is somewhat of a myth), you will learn to recognize the psoriasis shade by practice.

One could hardly mistake this eruption for any form of *eczema* if the entire eruption was exposed (as it always should be); scaly eczema almost always has had a previous moist stage, this has always been dry. I have never known eczema to present so many isolated spots and as small. I have seen ringworms, *tinea circinata* covering the entire body, but such cases are very rare and the great extent of this eruption would readily distinguish it from the common forms, as also would a microscopic examination of the scales. I have never seen a case of *erythematous lupus* which could be confounded with psoriasis although authors mention it, nor do I know of any other disease which you could reasonably suspect this to be, unless it were *tinea* or *pityriasis versicolor*. But here the patches, which may be small and circular and extend even down upon the arms, are always brownish-fawn color, without a shade of red, and the microscopic demonstration of the vegetable parasite, *microsporon furfur* is very simple, and certain, when the *tinea* is present. The man says that this eruption appeared, on the last occasion, after bathing in the salt water : I have a number of times known this small and very generally distributed eruption of psoriasis occur as it were in an acute manner after bathing in the sea, or after chilling of the surface, while we know that the chronic variety, with a tendency to large patches, comes on most unaccountably, and seldom can any local or special exciting cause be found. Psoriasis exhibits well marked and unmistakable evidences of a constitutional origin, although it may be difficult to trace it in every case, especially among the poor, and the sudden appearance of a diffuse eruption following a definite cause, as severe sea bathing, but shows the intensity of the constitutional disturbance responding to general stimulation of the integument.

We shall give this man tar internally, combined with an alkali, in the following prescription, which has been of service in other cases ; it is the "*liquor picis alkalinus*" which you have often seen prescribed here externally with such success. The formula is as follows : *R. Picis liquidæ, 3 ij. ; Potass. Causticæ, 3 ; Aquæ, 3 v. M.* Dissolve the potassa in the water and add slowly to the tar, with friction in a mortar. Commence with fifteen drops and increase slowly to half a teaspoonful after meals in considerable water.

CASE II. *Untreated syphilis, late tubercular ulcerations.* The case of this German, aged 25, is interesting, as showing the course of syphilis when left to itself, such cases as this demonstrating clearly the untenability of anti-mercurialistic doctrines, for, you know, certain writers, happily few and obscure, have urged that the ulcerations observed in the subject of Syphilis are the result of the

mercury and not of the disease. This man contracted a chancre in 1868, which was treated locally and disappeared, and he acknowledges no syphilitic history except sore throat, rheumatism and headache, *and he has never received any internal treatment* for these or other syphilitic symptoms.

Two years ago the present eruption began near the inner malleolus of the right leg, and has continued in increasing severity, in spite of various local applications, until now you see the entire left leg, except the upper quarter, is involved in a mass of ulcerating lesions, whose sickening odor at his first visit filled the room. This diseased surface is made up of masses of tubercular deposit, with cicatricial tissues between each of these foul ulcers with sharp livid edges and pultaceous base, representing separate syphilitic neoplasms. On the right side of the head and forehead, you see similar ulcerating masses and a number of cicatrices, entirely devoid of hair.

This man has been under treatment at one of the Homœopathic Public Institutions for some months, where the sores had been subjected to constant local treatment, but no internal remedies whatever have been employed: they have steadily gotten worse, until now he is indeed an object of pity.

The elements of diagnosis in the present case are, the large amount of ulcerative surface, its character and distribution. Seldom will one see such a leg as this apart from syphilis; varicose and eczematous ulcers of the leg are very rarely so extensive as this, their surface is not so riddled by ulceration, the base of the ulcers is more clean, with less of this necrotic tissue; moreover, the ulcerations and cicatrices of the scalp are evidently of the same character, and as it would be impossible for them to be eczema, from their appearance in this locality, those on the leg must also be of another origin. This combined picture, then, can be afforded by no other disease but syphilis; it is hardly possible to see how the true nature of this disease could have escaped recognition so long.

We gave him no local treatment, but allowed him to continue what he is now using, a carbolic ointment, in order to demonstrate how completely such ulcerative processes are under the control of the proper constitutional measures. One week ago he received our ordinary mixed treatment, containing $\frac{1}{32}$ grain of bichloride of mercury, about eight grains of iodide of potassium, two grains of iron, a little tincture of nux vomica, and compound tincture of cinchona, in each dose, after meals, thrice daily, and those who remember his state then, will see the wonderful power of the treatment. The offensive odor has entirely departed, some of the ulcerations have already healed, especially on the head, and all the diseased surfaces have taken on a healthy action. In such cases you can pretty confidently predict a perfect and quite speedy recovery.

CASE III. *Warts cured by arsenic internally.* This girl, of 11 years, exhibits now nothing of importance diagnostically, there being but a single ordinary wart on the inside of the third finger of

the right hand. The case is interesting, however, because when she first came here, June 2, she had ten of these deformities, a number being on the face ; and these have all disappeared, except this one, solely under the internal use of arsenic. Three weeks after her first visit, it is recorded that several of the warts had disappeared.

CASE IV. *Scabies, difficult of recognition.* I venture to say that very few, other than those specially practising dermatology, would recognize that this young man, aged 19, has scabies ; and yet the evidences are so clear that there cannot be a shadow of a doubt in reference to the true nature of the disease. The unusual features in the case are, that no history can be gotten of contagion (for generally the disease can be traced), and that there is such a very slight development of the eruption on the parts commonly recognized as liable to be affected. If we look on the sides of and between the fingers we find almost no eruption, a few small papules presenting nothing characteristic ; except here, between the thumb and forefinger of right hand, we find a distinct and well marked *cuniculus*, or *furrow*, and another not quite so clear. These minute, blackish, irregular, pretty sharply defined, curved lines are the one sure clinical sign of the disease, and the extraction of the acarus from them, and its demonstration beneath the microscope, would furnish evidence beyond doubt, even for the most skeptical. There are some papules and vesicles on the flexor surface of the wrists, but no distinct cuniculi or furrows can be seen here.

You heard me ask him almost immediately after inspecting the hands and the wrists, whether he had any eruption or any itching about the genitals, and here, upon the penis, we find the same small, scratched papules, and on the glans itself a cuniculus is plainly visible. I think that enough attention has not been called to the fact that in the male the penis or scrotum, or both, will very generally be affected in scabies. The constant touching these organs in answering the calls of nature, and the habit some have of handling the genitals when in bed, give abundant opportunities for the acari to pass thence from the hands, where we must believe they generally find their first lodgment. In the female it is very common to find the breasts thus affected in scabies, and some French writer has claimed that eczema of the breast in women who are neither nursing nor pregnant, is always dependent upon scabies, a rather too broad statement. These few papules, therefore, upon the sides of the fingers, between the right thumb and forefinger, and on the penis, are quite sufficient to characterize the disease as scabies, even if the cuniculi were absent, for I do not know that such a combined picture is furnished by any other disease of the skin. This, you will understand, is a very mild case of scabies ; there are very few of the results of scratching, pustules, &c., though he says that the whole body itches much at times : the disease is comparatively recent, he having perceived it only two weeks. It will yield completely, I expect, to a thorough warm bath, with yellow soap, and then a patient friction with the sulphur ointment of

the U. S. Pharmacopœia for a few nights, leaving the ointment on. This fellow's skin is pretty hard, and there are no excoriations, or such a procedure would be much too harsh: for scabies in women and children, you will see me prescribe storax, two drachms to the ounce, with, perhaps, a little sulphur, say a drachm or so.

CASE V. *Venous dilation in the skin.* It is rather difficult to locate the exact position in dermatological nosology, of the lesion on this woman's leg. It is evidently the same process as occurs in the ordinary varicose veins, indeed this latter condition is also found to a very marked degree on her legs; but here on the left, extending over a distance of about eight inches up from the internal malleolus, by three or four wide at its broadest part, we find an almost continuous varicosity of very small veins or capillaries, and these are seen to be very near the surface, and light pressure over the dark purplish-brown surface (which causes much pain) shows that moving blood is contained beneath a very thin covering. On the upper portion where the disease has seemed to be spreading, a sort of purpuric state has preceded this dilation, and we have up here simply a staining, as though a diapedesis had occurred, or a minute capillary rupture, for this coloration is not altered at all by pressure.

What I want to call particular attention to is the great comfort and benefit she has derived from painting the leg once or twice daily, two or three coats, with flexible collodion (Collodii 3 i. ; Olei Ricini, gtt. v. M.). The tenderness has now very largely disappeared and she can stand on the leg with ease; the tendency to increase seems also to be somewhat checked. She has been taking half a drachm of the fluid extract of ergot, three times a day, for some little time, but I have some doubt as to the amount of good effected thereby in this disease. Certain it is, however, that she has obtained great assistance from the use of the collodion, as suggested by my friend Dr Engelsted of Copenhagen, when at the clinic a week ago.

Society Transactions.

AMERICAN DERMATOLOGICAL ASSOCIATION.

REPORTED BY DR. BULKLEY, SECRETARY.

The American Dermatological Association was organized on Wednesday, September 6th, 1876, in accordance with the following call :

NEW YORK, JULY . . 1876.

DEAR SIR,—At an informal meeting of the undersigned, held in Philadelphia, at the rooms of the Section of Practical Medicine, of the American Medical Association, Wednesday, June 7th, 1876, after the election of a Chairman and Secretary, *pro tem.*, it was *Resolved*, To call upon such American Physicians as had evinced a special interest in Dermatology, to unite in forming an American Dermatological Association. *Resolved*, That the meeting for organization be held in the University of Pennsylvania, Philadelphia, on Wednesday, September 6th, 1876, at 6 P.M., or immediately after the close of the meeting of the Section of Dermatology and Syphilology, of the International Medical Congress, on that day. It is sincerely desired that you will be present and aid in the organization. Please signify your pleasure to the Secretary at the earliest opportunity, and oblige,

Very truly yours,

L. D. BULKLEY, Secretary, *pro tem.*,
1 East 33d St., New York.

LOUIS A. DUHRING,
Philadelphia, Pa.

EDW. WIGGLESWORTH,
Chairman,
Boston, Mass.

LUNSFORD P. YANDELL, JR.,
Louisville, Ky.

J. E. ATKINSON,
Baltimore, Md.

GEORGE HENRY FOX,
New York.

This call was sent to about fifty physicians in the various parts of the United States whose names were known, in connection with Dermatology, and suggested by the informal committee issuing the call.

Twenty-three gentlemen responded, and these, together with the six signers of the call, comprise the twenty-nine original members of the Association.

The Meeting for organization was called to order by the chairman of the committee issuing the call, Dr. Wigglesworth, of Boston, on Wednesday, September 6th, 1876, at six o'clock. The following gentlemen were present at the organization, Drs. J. E. Atkinson, Baltimore, Md.; T. R. Brown, Baltimore, Md.; L. Duncan Bulkley, New York; S. C. Busey, Washington, D.C.; Louis A. Duhring, Philadelphia; C. Heitzman, New York; E. L. Keyes, New York; J. A. Octerlony, Louisville, Ky.; H. G. Piffard, New York; R. W. Taylor, New York; Arthur Van Harlingen, Philadelphia; F. D. Weisse, New York; James C. White, Boston; Edward Wigglesworth, Jr., Boston.

Dr. Wigglesworth was continued in the chair, and Dr. Bulkley elected secretary of the meeting for organization, and a committee was appointed, consisting of Drs. Bulkley, Octerlony and Van Harlingen to prepare a constitution and by-laws and to make nominations for officers.

The Constitution and By-Laws offered were discussed, amended and adopted, section by section, and at an adjourned meeting on Thursday, September 7th, they were adopted *in toto*, the American Dermatological Association was declared organized, and the following officers were elected for the coming year.

President.—JAMES C. WHITE, M.D., of Boston.

Vice-Presidents.— { LOUIS A. DUHRING, M.D., of Philadelphia.
 { R. W. TAYLOR, M.D., of New York.

Secretary.—L. DUNCAN BULKLEY, M.D., of New York.

Treasurer.—JAMES NEVINS HYDE, M.D., of Chicago.

The Association then adjourned to meet on the first Tuesday in September, 1877, at Niagara Falls.

INTERNATIONAL MEDICAL CONGRESS.

SECTION OF DERMATOLOGY AND SYPHILOLOGY.*

Philadelphia, September 4th-9th, 1876.

FIRST DAY.

The Section was organized with Prof. Jas. C. White, of Harvard University, in the chair, and Dr. Arthur Van Harlingen, of Philadelphia, Secretary.

FIRST QUESTION.—“*Variations in Type and in Prevalence of Diseases of the skin in Different Countries of equal Civilization.*” James C. White, M. D., Professor of Dermatology in Harvard University, Reporter.

* We are indebted to the New York Medical Record for some of the material used in this report.

This paper was based on statistics drawn from reports of leading dermatologists of Europe and America, embracing 50,000 cases from abroad, with 12,000 observed in this country.

As a result of examination and comparison of these statistics, he deduced certain conclusions embraced in a series of propositions, as follows :

1. Certain obscure affections, the etiology of which is little if at all understood, even in those parts of Europe to which they are mostly confined, may be regarded as practically non-existent among us. Of such are prurigo, pellagra, and lichen exudativus ruber.

2. Certain diseases, directly connected with and dependent on poverty and habits of personal uncleanness, are less prevalent in the United States than in those parts of Europe of which we have sufficient statistical information for comparison. Examples of this class are the animal parasitic affections especially.

3. Some cutaneous affections of grave character, dependent on, or a part of serious constitutional disorders, are of less frequent occurrence and of milder type amongst us than in Europe in general, or those parts of it where they are endemic. Lupus, the syphiloderma, and leprosy are the most marked instances of this class.

4. Certain disorders of the skin, especially those connected more immediately with its glandular and nervous systems, are apparently more prevalent with us than in Europe. The most notable examples of the former are : seborrhœa, acne, and possibly, heat rashes ; of the latter, herpes, urticaria, and pruritus.

Considerable discussion ensued regarding some of these points. Dr. Duhring, of Philadelphia, thought that massing the figures from the three cities, Boston, Philadelphia and New York, gave a fallacious impression with respect to diseases in any one of these cities.

Dr. Bulkley, of New York, replied that the same discrepancy would be found to exist between the statistics of successive years in the same institution. He thought, however, that by collating the figures derived from reports of these localities, extending over a series of years, as the reporter had done, a very fair idea could be obtained of the prevalent skin diseases of the country.

Some discussion also took place on the use of the term morphœa by the reporter, and the relations borne by this disease to other affections sometimes called by the same name, as Addison's keloid, linear atrophy and scleroderma. Various opinions were expressed by Drs. Bulkley and Duhring, and by the reporter, the conclusion finally reached being that the term morphœa had been used in the sense generally understood by American dermatologists. The reporter's propositions were then taken up one by one.

On the subject of some of the affections mentioned, as prurigo and leprosy, no difference of opinion seemed to exist relative to the occurrence of these affections now in America. As regards leprosy, Dr. Bulkley related two cases which had come under his care, occurring in persons of healthy American parentage, who had never been sixty miles away from New York. Cases were

alluded to by the reporter as occurring in some of the Southern States, as well as the well-known leper colony in Nova Scotia. As regards the severity of syphilis, as it is found in this country, the different members of the Section seem to have had a different experience. Dr. Duhring said he was quite sure he had seen as large a proportion of very severe cases of this disease in Philadelphia as he had seen abroad.

The various propositions presented by the reporter were finally passed, it being placed on record, however, that the sense of the Section regarding the third proposition was understood to be, that lupus vulgaris is of a milder type and less prevalent in this country than in Europe; that leprosy is not sufficiently known to warrant an expression of opinion as to its severity; and that, upon the subject of the syphilodermata, the Section differ from the reporter.

Dr. Bulkley offered the following additional proposition, which was adopted by the Section:—The type of certain acute congestive and nervous diseases of the skin is more severe in this country than abroad.

SECOND DAY.

SECOND QUESTION.—“*Are Eczema and Psoriasis Local Diseases, or are they manifestations of Constitutional Disorders?*” Lucius Duncan Bulkley, M. D., of New York, Reporter.

The reporter considered the nature of the eruption in constitutional disorders affecting the skin, as in the contagious fevers, syphilis, etc., and also the characteristics of local diseases; also the microscopic anatomy of eczema and psoriasis. He then studied the clinical history of eczema and psoriasis, according to age, sex, location, relapses, hereditary transmission, gouty and rheumatic symptoms, urinary disturbances, bronchitis, etc. He then examined into the clinical history of local diseases, epithelioma, verruca, parasitic and mechanical diseases of the skin, etc., the effect of local and constitutional treatment, etc. The propositions brought forward by him roused much opposition, and were debated one after another, the discussion lasting the entire afternoon. The debate seemed chiefly to turn upon the nature of eczema, and the various pathological theories connected with dyscrasia, diseases of the blood and cellular pathology, as bearing upon this affection.

The propositions as finally adopted by the Section were as follows:

1. Eczema and psoriasis are diseases *sui generis*, and are not to be confounded in any way with other states; as, the former with artificial dermatitis, and the latter with the eruptions of syphilis, scaly eczema, or leprosy.

2. Eczema and psoriasis cannot own a double independent causation or nature, at one time local and at another constitutional; but, with other diseases, they may have a twofold cause, namely, a predisposing and an exciting.

3. Eczema and psoriasis in many of their features resemble the accepted constitutional diseases more than those recognized as local.

4. Local causes play an important part in the etiology of eczema; they are probably inoperative in psoriasis.

5. Certain relationships between psoriasis and epithelioma have been claimed, which require much further investigation. At present they are not established, and are no proof of the local nature of psoriasis.

6. No direct causal connection has yet been demonstrated between the scrofulous state and eczema and psoriasis.

7. Local treatment is often insufficient alone to remove the lesions of eczema and psoriasis, and cannot prevent or delay relapses.

8. The success of local treatment in eczema and psoriasis does not demonstrate the local nature of these affections.

9. Constitutional treatment alone and singly can cure many cases of eczema and psoriasis, and prevent or delay relapses in a certain proportion of cases; under constitutional treatment it is intended to signify every agency not properly placed among local measures.

10. The total weight of argument is, that eczema and psoriasis are both manifestations of constitutional disorders, and not local diseases of the skin.

Prof. Rudnew, of St. Petersburg, then read a paper entitled, "*What is the disease known as lupus?*" by Dr. Woskrensky, of the Institution of Pathological Anatomy, St. Petersburg, under Prof. Rudnew's directions. The name lupus was originally loosely applied, just as "sarcoma," "cancer," etc., were. The changes of the tissues in lupus, he thought, have no signs by which it can be considered a separate and independent disease; it is merely a name applied to several species of tumors. From personal observations in facial cases, he considered that all the different varieties might be classed under three divisions:—1, a form which is simply a horny cancer, and incurable; 2, adenoma simplex or combined with cancer; 3, granuloma syphiliticum, easily cured.

THIRD DAY.

THIRD QUESTION.—"*The Virus of Venereal Sores; its Unity or Duality.*" Freeman J. Bumstead, M. D., late Professor of Venereal Diseases at the College of Physicians and Surgeons, New York, Reporter.

Three views as to the origin of venereal sores have been entertained:

1st. All venereal sores are due to the specific virus, the virus of syphilis.

2d. Some venereal sores are due to the syphilitic virus, and others to a distinct virus, known as the chancroidal.

3rd. Some venereal sores are due to the syphilitic virus, and others to the inoculation of the products of simple inflammation, in which latter case no specific virus exists.

The evidence for and against each of these suppositions, drawn from clinical experience and artificial inoculation was considered, and the conclusions of the Reporter were stated in the following propositions :

1. The virus of venereal sores is dual.
2. Venereal sores may be due to the inoculation of the syphilitic virus, and also to the inoculation of the products of simple inflammation.
3. These two poisons may be inoculated simultaneously.

The second proposition aroused a lively debate, the reporter being understood to express the view that there was no specific chancroidal virus. At the suggestion of the chairman, the proposition was divided into two sections. The first of these was passed without discussion ; but as to the second, all that portion of the original proposition which follows the word "virus" was, after long debate, rejected by the Section.

In connection with the second proposition, Dr. Bulkley offered the following, which was adopted by the Section :

"The present state of science has demonstrated that suppurative inflammatory lesions resembling chancroids may be produced on different portions of the body by inoculation with simple pus from various lesions."

A paper by Dr. Drysdale, of London, bearing the same title as that of Dr. Bumstead, was then presented by the Secretary, and, on motion, was passed by title.

The Secretary then read a paper entitled "*Leprosy in the Sandwich Islands*," by Dr. F. H. Enders, Government physician.

It was believed by some to have been introduced from China, but probably this was not so. The writer was unable to say positively whether it was a disease *sui generis*, or a form of syphilis, although he inclined to the latter view. He had seen over four hundred cases, all of whom except two had had syphilis. Two forms of leprosy were met with, the anæsthetic and the tubercular, cases of which were cited. Many interesting facts in its history, treatment, etc., were given.

Dr. Heitzmann, of New York, read a paper on "*The Treatment of Seborrhæa*."

The treatment recommended was by tar, or Oleum Rusci, a drachm to the ounce of coldcream ointment, well applied every night. In discussion a number of the members stated that they had employed the same remedy for several years, and could attest its value.

FOURTH DAY.

FOURTH QUESTION.—“*The Treatment of Syphilis, with Special Reference to the Constitutional Remedies appropriate to its various Stages; the Duration of their Use, and the Question of their Continuous or Intermittent Employment.*” E. L. Keyes, M. D., Adjunct Professor of Surgery and Professor of Dermatology in Bellevue Hospital Medical College, New York, Reporter.

The following synopsis indicates the line of thought :

1st. Does a mild beginning in syphilis necessarily indicate that the malady will run a mild course, so that the duration of the treatment may be regulated thereby?

2nd. Is the internal use of mercury debilitating?

3rd. When is mercury useful in syphilis? Has it any control over the late symptoms?

4th. When is iodine useful in syphilis? Can it replace mercury in any stage of the disease?

5th. Does iodine act by liberating mercury lying latent in the tissues.

6th. Should treatment be continuous or interrupted?

7th. General outline of a course of internal treatment.

8th. Conclusions, negative and positive.

The propositions presented were as follow :

Negative conclusions : *Views for which there would seem to be no foundation in fact.*

1. Syphilis commencing mildly needs but little treatment, and does not require mercury.

2. Mercury given internally is necessarily debilitating.

3. Mercury is only useful in secondary syphilis.

4. Iodide of potassium is of considerable value in secondary syphilis.

5. Iodide of potassium is of no value unless preceded by the use of mercury.

6. Iodide of potassium acts by liberating mercury which has been lying latent.

The following positive conclusions, which in the present state of our knowledge may be affirmed, were then enunciated by the Reporter, and laid before the Section.

1. Mercury is an antidote to the syphilitic poison, and of service in controlling all its symptoms in all, even to the latest stages of the disease; its power over gummata being least, and not to be relied upon.

2. Mercury in minute doses is a tonic.

3. Iodine cures certain symptoms of syphilis, but does not prevent relapses.

4. Mercury long continued uninterruptedly, so far as practicable, in small doses from the time of earliest eruption, constitutes the best treatment of syphilis.

These propositions gave rise to much debate, the discussion for the most part including the question of continuous or interrupt-

ed methods of treatment. It was finally conceded that the statement in regard to long continued uninterrupted treatment suggested rather the object to be aimed at, rather than that which is generally attainable.

Dr. Drysdale's paper, bearing a similar title to that of Dr. Keyes, was, on motion, accepted by title.

A paper by Dr. Ward, of Lima, entitled "*Verugas a Disease peculiar to Peru*," was, on recommendation of the committee appointed to examine it, passed by title.

FIFTH DAY.

Dr S. Engelsted, of Copenhagen, read a paper entitled "*Measures to prevent the Propagation of Venereal Diseases in Denmark*."

Some discussion on the subjects presented in the paper ensued, after which the following preamble and resolutions were proposed by Dr. Bulkley and adopted by the Section :

Whereas, After an interesting and valuable paper by Dr. Engelsted, of Copenhagen, in regard to the prevention of venereal diseases in Denmark, in which the laws which have been in successful operation there are given in full, with statistics showing very favorable results ;

Whereas, At recent meetings of the American Medical Association, Drs. Gross and Sims have advocated measures in reference to their control ; therefore,

Resolved, That this Section do recommend that the International Medical Congress, convened at Philadelphia, Sept. 4th-9th, 1876, do appoint a committee to consider the subject more fully, to collect statistics and data, and to report through the medical press, with a view to influence laws which shall have the aim of diminishing and rendering less severe venereal diseases throughout the world.

(These resolutions were presented to the Congress at its final session, but were not adopted.)

The regular papers were referred to the committee for publication. The paper on lupus was not accepted.

The Section then adjourned *sine die*.

Extracts and Translations.

ON A CASE OF FRAMBÆSIOID CONDYLOMATOUS SYPHILODERM OF THE HAIRY SCALP, CURED BY THE HYPODERMIC INJECTION OF CORROSIVE SUBLIMATE.*

Translated from the Italian of Tommaso de Amicis,

BY JAMES NEVINS HYDE, M. D. OF CHICAGO.

IT is a truth which is to-day only too well recognized, that there is no organ or tissue of the animal economy, which, in the long course of Constitutional Syphilis, can claim exemption from consequent modifications of nutrition—these modifications being of speedy manifestation, according to the time of the occurrence of infection and the period of evolution of the disease itself. Of all the tissues, the tegumentary possess a fatal supremacy in the frequency and number of their various localizations of the dysthetic process; while the skin particularly, even in preference to the mucous membrane, enjoys this disastrous prerogative, due chiefly to the functions which it discharges and its complicated structure.

No one to-day actually assents to the view formerly held that the skin is always an essentially identical structure, serving merely as the mechanical casement of the body, protecting it after the manner of a cuirass from external affronts. Thanks to microscopic anatomy, it is now, on the contrary, well known that the integument consists of a complexity of anatomical elements, endowed with the highest nutritive and functional activity, forming an integral part of the organized being; provided with a series of tissues and special apparatus, which are not to be found in any other system. These are: the stratum corneum, the stratum Malpighii, the sudoriparous and sebaceous glands, the abundantly

* Di un caso di Sifiloderma condilomatoso frambæsiaco del cuoio capellato, guarito con le iniezioni ipodermache al sublimato corrosivo. Pel dott. Tommaso de Amicis. Professore pareggiato di Sifilografia e Dermatologia nell' Università di Napoli. (Annali Clinici dello Ospedale Incurabili. Nuova Serie. Anno I. No. 2.)

supplied hair follicles, the papillary layer of the corium with its special provision for nervous sensation in the form of corpuscles, the corium, abounding in connective, vascular and muscular elements, blood vessels and lymphatics. Elements such as these are capable in themselves of displaying actual lesions, independent of alterations in the general organism, and yet, on the other hand, may become subject to pathological changes which sustain definite relations to disturbances in other systems and organs, on account of the special function which they have been deputed to discharge.

In fact the skin may be regarded, in its connection with the general organism, as an apparatus of a compensatory character, since it is first to reveal alterations of the general structure, and since also within its limits are completed those processes of depuration and compensation which accompany all zymotic and virulent conditions. It is thus readily understood why the skin offers to the syphilitic infection the vastest theatre for its multiplied external developments, since these form a series of perturbations of nutrition, which are, now hyperæmic, now phlogistic and yet again hyperplastic. Thus from the roseolous rash to the tubercle and gumma of the subcutaneous tissues, there is a long series of alterations which are to be classed under the general title of the Syphiloderm, which in their complexity still exhibit a special physiognomy, and which properly form one of the distinct groups in the system of natural classification of cutaneous diseases. (Alibert.)

The lesion which predominates in the inflammatory, otherwise named virulent, or secondary period of Syphilis is, without doubt, the flat condyloma, [*Die breite Condilomata, die feuchten oder nassenden Papeln, die flachen Condilome, papules humides, pustula foeda ani, pustules plates, plaques muqueuses etc.*,] to such an extent that Zeissl would have this called the condylomatous period. In this form of lesion, the epithelial stratum, but chiefly the mucous layer of the epidermis seems to be affected in a peculiar manner, and in this affection the papillary layer is concerned only to a secondary degree. There is a notable increase in the volume and number of the cells of the rete, which frequently display division of the nucleus and endogenous proliferation. The epithelial prolongations which lie in the inter-papillary spaces become larger and deeper, while the papillæ themselves become proportionally larger and swollen, with dilatation of their central vessel. Numerous nuclear elements are also infiltrated in their papillary network, and remain in an indifferent state, without a tendency to attain to the higher grades of organization, and therefore with a special tendency to readily undergo retrogressive phases, and to disappear without leaving a trace of cicatricial tissue. The inflammatory initiation, provoked by the virulent principle, may possibly be also diffused beneath the superficial stratum of the derma, properly so-called, and then induce an identical form of cellular infiltration. Hence, clinically,

different varieties of the flat condyloma may be distinguished, viz:—(a) the simple superficial flat condyloma, (b) the suppurating and ulcerating flat condyloma, (c) the vegetating flat condyloma, and (d) the hyperplastic or sclerotic flat condyloma.

The third of these varieties may be produced in either of two ways. First: it might be a phase of the suppurating flat condyloma, when, in consequence of the secretion of pus, the epithelial stratum is removed and the papillary layer is left exposed and consequently subjected to ordinary external irritation and the friction due to contact of two opposed surfaces: in consequence of which it undergoes an extraordinary development, (as, for example, in the genital region, the periphery of the anus, the internal faces of the thighs, the axillæ &c.) Or, second, in various localities, it may be even recognized as a primitive lesion, especially over the surfaces covered by hair, as the scalp, the face, &c. In both these cases, elevated vegetating tubercles appear, more or less grouped together, of a bright red hue, covered with a stratum of puriform mucus, which results from degeneration of the epithelial elements and increased sebaceous secretion, where decomposition gives origin to an unpleasant odor. These lesions are often found extended over a large space, and recall to the mind the aspect of the strawberry and the raspberry (*framboise*) whence the names, *Framboesia* (Sauvages) *Framboesia Syphilitica* of other authors, *Pian Ruboide*, *Mykosis Framboesioides* of Alibert, and *Syphilomykes*, (Fuchs.)

Sauvages was the first to introduce into cutaneous literature the name *Framboesia*, in describing a contagious malady, endemic in the islands of the West Indies and in Africa (Guinea.) It was described, after the 10th century, by Arabian physicians, under the title *Sahafati*, and was then more frequently observed in the negro race. It is now however found in other regions of South America, where it is known as *Pian* or *Yaws*, (strawberry and raspberry, because the excrescences which are developed upon the external integument and chiefly upon the genitals and around the arms, the axillary cavity and elsewhere, resemble the fruits named. Now this affection, on account of the mode of its commencement and development, the pathological peculiarities of its products, and its obedience to the influence of specific remedies (mercury), has been, by the majority of authors relegated to the domain of syphilis, even contrary to the opinion of Sauvages himself, and of others who would consider it a very different malady. Alibert has given much consideration to the vegetating forms of syphilis and, in the division allotted to mycosis, describes; (1) mykosis framboesioides; (2) mykosis fungoides; (3) mykosis syphiloides. But in the latter category are comprised several non-syphilitic lesions, and, under the name mykosis fungoides, Kaposi, Devergie, Neumann and others hold that he has described a form of acne molluscum; while Demange (*Annales de Dermatologie et de Syphiligraphie*, 1874) describes under the same name (mykosis fungoides) an alteration of the skin which was demonstrated, by histo-

logical examination, to be a neoplasm of glandular origin, and which therefore he thought would be appropriately denominated "cutaneous lympho-adenoma." Alibert believes* that the *pian ruboides* or *Yaws of Guinea*, the *pian fungoides* or *pian of the Malacca Islands*, the *Sibbens* of the Scotch (from the resemblance to the wild raspberry called *sevin*: hence, *sevin*, *sibbens* or *simens*) and the *therminthes* of ancient authors, are quite analogous affections.

All these forms to which so many and such various denominations have been given, ought to be alike considered as varieties of the flat vegetating condyloma, which readily manifest themselves in syphilitic individuals who take little care of their persons, who perspire freely, and who never bathe. These conditions usually obtain in hot climates, in the midst of the burning sands of Africa, or the banks of the Senegal, and in the impure atmosphere of Guinea, among the negroes whose skin is often inundated with perspiration, and among whom there is total neglect of the ordinary precautions for cleanliness. The disease then is the unfortunate appanage of the inhabitants of the torrid zone.

It should be remembered, however, that all forms of vegetation which occur in syphilitic individuals, are not in every case metamorphic phases of the flat condyloma, but may arise as species of papillary vegetation from other infiltrations of syphilitic origin, caused solely by deviation from the process of granulation (syphilis cutanea papillomatosa seu vegetans,) conditions which frequently obtain in the course of repair of extensive rupial ulcerations or serpiginous exulcerated syphilodermata.

And yet if these framboesiod lesions are more frequently a symptomatic expression of constitutional syphilis, it must be admitted that cases occur where the framboesia is idiopathic, and, at various periods, originates from the influences which cause chronic inflammation of the corium. These phenomena may follow, both readily and rapidly, lupoid and scrofulous ulcerations, the period of repair of phagedenic ulcers, burns, pemphigus, sycosis, &c. † Such papillomatous forms as these are difficult to distinguish, by their peculiar morphological characters, from the similar syphilitic varieties (especially that last described) unless the concomitant and collected facts be taken into consideration, and their career carefully studied. It is therefore clear that the name, framboesia, should not be regarded as the designation of a disease *sui generis*, but as a morphological modality which may occur in the course of papillary vegetations, such as arise from processes of different kinds.

Subjoined is the history of a rare case of vegetating Syphilide of the face and more especially of the hairy scalp, which suggested the framboesia of Sauvages and the descriptions of the Pian

* Descriptions de maladies de la peau, Paris, 1814.

† During the last two years we had the opportunity of studying a fine case of vegetating papillomatous dermatitis, following pemphigus, in the 4th ward (males) of this hospital.

and Yaws: The patient was under observation, during the last year, in the 4th Ward of the Hospital (females), of which Prof. De Sena is director, and where, associated with my friend Prof. Tenore, I discharge the duties of Assistant Physician. The case is worthy of record, if only on account of the success of the treatment adopted.

E. Pasqua of Naples, 25 years old and of good constitutional vigor, declares that she never was ill till the beginning of the past year, when, as she states, she was married. She became pregnant during the month of July of the same year, and three months thereafter, discovered the existence of reddish maculæ upon the breast, the face, and in particular upon the frontal region, which persisted for a very long time, and finally became transformed into the lesions which are now to be seen.

Simultaneously with this eruption there occurred alopecia, and ulceration about the isthmus of the fauces, but she did not remember that she had suffered from any affection of the genitals, nor was she advised respecting the health of her husband. She was sent to the Hospital for Incurables, Oct. 13, 1874.

When examined there, the patient was seen to be well developed and possessed of fair constitutional vigor, but her nutrition was somewhat at fault, and her general color suggested the pallor of anæmia. In no region of the body were lesions observed, except upon the hairy scalp and some points of the face, while the cervical and inguinal glands were notably multiple, enlarged and painless. The eruption upon the scalp was limited as follows: it extended from the frontal region almost at the line of commencement of the hair, as far as the occipital region, forming anteriorly, a continuous superficies, and showing itself posteriorly in disseminated points; laterally, spreading to the borders of the temporal and parietal regions, somewhat more extensively on the right side. The surface of this eruption was irregular, with interspersed depressions here and there, even where the eruption formed a continuous elevated plane, clearly indicating that the association of different tubercles, each as large as a coin of the size of one or two centimes, which were at first isolated and then by increment of growth had become united by their respective margins—a condition which was much more evident in the occipital region. Each of these nummular vegetating masses when isolated, was evidently raised above the cutaneous surface to the extent of three centimetres, and was found to be composed of a group of smaller club or nipple-shaped vegetations, whose aspect was strikingly suggestive of the raspberry or strawberry. Their hue was a pale red, and they were covered with a stratum of viscid puriform mucus, which was more abundant in the interspaces separating the vegetating masses; dried, at some points, so as to form a yellowish grey crust. This secretion possessed an intensely disagreeable odor.

The patient, aside from the annoyance occasioned by the offensive odor and the more or less abundant secretion which flowed over the neighboring parts, was not inconvenienced by the local

affection, which occasioned no painful sensations. The isolated tubercles situated upon the occipital region varied in size from that of the coins of 2 to 10 centimes. Identical vegetations were situated upon the right and left naso-labial sulci; these exhibited a vividly red color; and, not only in this respect but in point of size, resembled the raspberry fruit. At no point upon the scalp were there ulcerations of any kind.

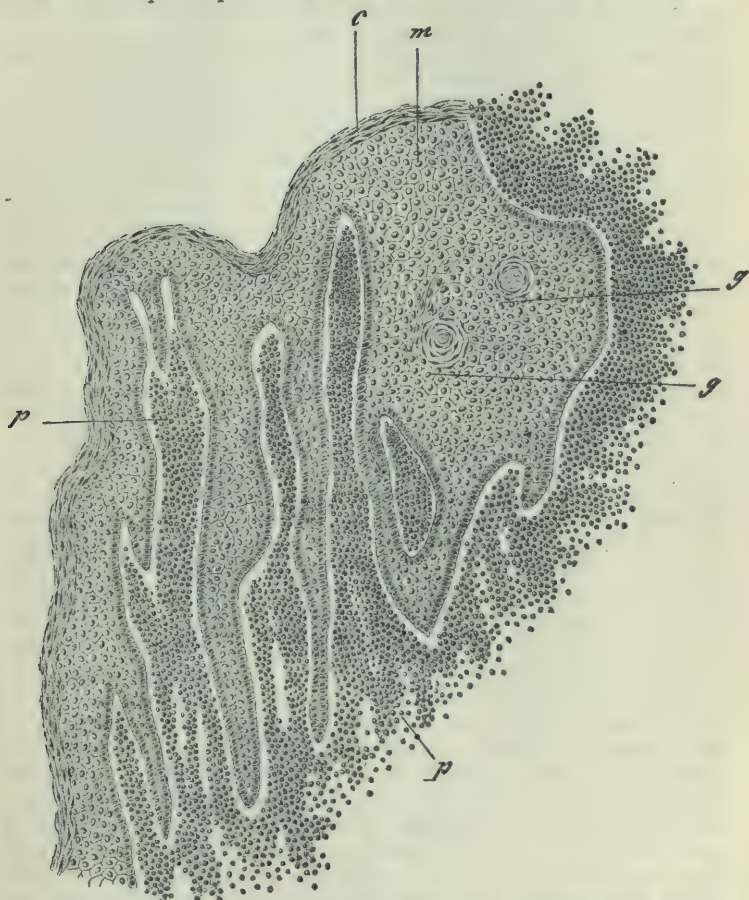
The patient complained of peri-articular pains in the upper and lower extremities.

In the month of January, when the patient first came under our observation, the pregnancy had advanced as far as the 7th month, and proceeded regularly except in so far as the patient exhibited a marked tendency to attacks of syncope and convulsions.

Was this species of frambœsoid vegetation an idiopathic affection of the scalp, succeeding chronic inflammation of the corium; and should it therefore be regarded as a simple papillomatous dermatitis of the tissues in that locality? Or should it rather be regarded as in close connection with a diathesis—in this case the syphilitic diathesis—constituting one of the phases of the flat condyloma already described? The response cannot admit of doubt, if we consider the mode of its origin, the concomitant facts, and the form of the eruption itself. For these reasons we decided that syphilis was the cause of the malady; and, recalling its resemblance to the *frambœsia* of Sauvages, termed it a frambœsoid condylomatous syphiloderm. One should not be deterred from admitting such a diagnosis by the assurance of the woman that she had never suffered from ulcerative lesions of the genitals, because the apothegm of Ricord that “an ulcer is the sole portal for the entrance of syphilis,” cannot be unreservedly accepted. It is well established that the initial accident, instead of assuming the characters of an ulceration, may be a circumscribed neoplasm (sclerosis, initial induration); may appear as a nodule (split pea of B. Bell); may present the foliaceous or papiraceous form (Fournier) and may disappear by gradual resorption without leaving a cicatricial trace of its existence. In the present instance we are not in position to demonstrate the non-priority of such accidents.

In order, however, to better comprehend the anatomical structure of this lesion, we excised a portion of the vegetating mass from a surface where there was no excoriation. The section was followed by copious hemorrhage, which was controlled by styptics. The excised portion was first hardened in alcohol, and then successive sections were submitted to microscopical examination. The results are shown in the Figure. The stratum corneum (*c*) was in no wise altered. The stratum malpighii (*m*) was, actually and relatively, much enlarged, and its process-like prolongations were deeply insinuated between the papillæ. There was manifest hypertrophy of the papillary portions of the corium. The projecting and occasionally ramifying papillæ (*p*) exhibited abundant cell infiltration of minute nuclear elements in an indifferent state, which extended even to the reticular stratum of the corium.

It is thus evident that microscopical investigation confirms the facts obtained by clinical observations, which are precisely those observed in the vegetating flat condyloma—viz., hyperplasia of the rete mucosum and of the papillary layer, in which, also, there is well marked participation of the vascular elements, as the abun-



Vertical section of the framboesiod vegetation removed from the hairy scalp,—3 and 4 Hartn.

- c. Stratum corneum.
- m. " mucosum.
- i. Epidermoidal globules.
- p. Papillary layer of corium.

dant hemorrhage consecutive to the wound demonstrated. In no point was there ulceration, for the copious secretion noticed upon the surface of the vegetation was occasioned by increased activity of the sebaceous glands, with rapid exfoliation, and fatty degenera-

tion of the epithelial cells of the rete. The offensive osmosis was due to the formation of fatty acids, which changed the character of the secretion, permitting its accumulation between the separate groups of vegetating tubercles.

The diagnosis being thus established, the indications for treatment were two-fold; viz.—first, generally to treat the syphilis as the underlying pathological condition; and, second, to modify the local manifestation, so as to determine its retrogression and final disappearance. With reference to the first point, we agreed with Professor De Sena in ordering mercury, being convinced of its great utility, especially in the inflammatory period of syphilis. This general treatment was the more urgently required on account of the pregnancy, and the possibility of an abortion induced by foetal or placental alterations. As our distinguished predecessor in the service of the ward had already directed mercurial inunction for the patient, and this treatment had been inaugurated, we thought proper to continue it.

In the way of local treatment, it was necessary to renounce the aid of topical remedial applications during the continuation of the pregnancy, since there was so much hyperæsthesia and sensitiveness that the application of a simple lotion of Labarraque's solution was sufficient to induce convulsive attacks. We, therefore, contented ourselves with ablution of the parts with a decoction of chamomile, merely to secure cleanliness, waiting for the completion of pregnancy in order to pursue a more energetic treatment. This period of expectancy was, however, short, as premature labor occurred, February 1st (8th month), when the patient brought into the world a well-formed, but poorly developed living child, presenting no maculæ of the surface, or lesion which might be referred to syphilis, but nevertheless exhibiting the characteristic features of senility in miniature.

On the following day the infant was sent to the Hospital of the Annunciation, and I had no further opportunity of observing it, with a view to determine the probable development of hereditary syphilis; for, as I learned from Professor Somma, physician of the last-named charity, the child remained there but five days, having been then adopted by a mother who had recently lost her own child. Was it for the latter a fortunate circumstance that, all unconscious of danger, she brought the infant into the sanctuary of her family, and made it the object of that maternal care and tenderness which surpass all need? or did the innocent victim of another's transgression become a fruitful source of evil in its acquired domicile, by inoculating her who gave it a new lease of life with the virus of the disease which had become its sad heritage at birth? The response can scarcely be doubted. *

* May I be permitted to call the attention of our legislators to a defect in the regulations enforced in the hospitals for abandoned children, which seems to me to have an important bearing upon public hygiene? While every care is taken to isolate and surround with barriers the sources from which syphilis is disseminated, by regulating prostitution, by substituting animal vaccination for that from

In the case of our patient, acute febrile symptoms were developed between the 4th and 6th of February, which were followed by an abundant secretion of milk. As there was no necessity for sustaining this activity of the mammary function, we attempted its suppression by the administration of generous doses of the iodide of potassium; and, in the course of four days, the dose of this remedy was increased from one to three grammes. The desired result was obtained. By February 15th, the secretion of milk had entirely ceased, and on the 18th, the medication was discontinued. Thereafter, retrogression from the puerperal state continued normally.

In spite, however, of the mercurial inunction, continued during the month of January, and suspended on the supervision of labor, there was no perceptible modification of the cutaneous syphiloderm. This want of success was attributed to the unsatisfactory method of inunction, rather than to inefficiency of the medicament. We, therefore, determined to employ hypodermic injections of corrosive sublimate; and, in order to better observe the influence of this mode of treatment, we made no topical application to the lesion, ex-

arm to arm, &c., a much more ready means of diffusing the disease has attracted no attention. Any child whatever, whose antecedents are unknown as well as the locality from which it came, may be adopted by the first one who asks for it the day after its entrance into hospital. If to this it be answered, that whoever assumes charge of it will be sufficiently interested to bring it back again, as soon as it is found to be diseased, I reply that just there lies the difficulty. The interested person returns only after all the harm has been done. What ordinarily happens in such cases? The so-called "Child of the Madonna," after a month or two passed in the family of some honest peasant, has condylamata of the lip or tongue. The members of the household either remain ignorant of it, or, if they happen to notice it, conclude that is a simple aphthous disorder,—apply a little honey of roses, and think no more of it. After some days, condylamata appear about the genitals. They think it has been "over-heated," and make some equally simple local application. All the family continue to caress it, and the same nurse suckles it, until she finds a solution of continuity upon one of her nipples—a mere erosion. This she calls a "crack," and applies to it a simple ointment. Finally, constitutional symptoms appear in the nurse, which she in turn communicates to her husband. Meantime the infant has transmitted the disease to those who have habitually kissed and fondled it, and employed the same utensils in the administration of food. The source of the disease is only made clear when the domestic peace of the husband and wife is disturbed by the mutual recriminations, based upon the new state of affairs. At last they summon to their aid a physician, who is skilful enough to trace the calamity to its source, and *then* the infant is sent back to the foundling's hospital! But if all goes well, and if the phenomena are of no great importance, the disease will remain unrecognized, will pass into a condition of latency, to reappear at no distant date, spread even more widely, and constitute the origin of one of those epidemics of syphilis which are only too frequent in various parts of Italy, and which remain for a long time unrecognized.

On account of these considerations, it would seem necessary to modify, in the interests of public safety, the mode of disposing of children received at the foundling hospitals. It should be at least established that such as come to the hospital with clearly suspicious antecedents, should be kept there under observation during the first three months, in order to have the assurance of the possible appearance of syphilitic manifestations. Or, if removed before that period has elapsed, they should be subjected to scrupulous vigilance in the places to which they have been transferred.

cepting repeated lotions with Labarraque's solution, with a view to modify the disgusting odor of the secretion.

The solution employed for injection was that which we commonly use, viz: distilled water and the bichloride of mercury, in the proportion of one centigramme of the latter, to a gramme of distilled water (1:100) without the addition of alcohol. We had learned by experience that the solution above given was more perfect, and that the alcohol was not only superfluous, but tended to irritate the tissues, and render the trifling operation more painful.* A syringe having the capacity of one gramme, was filled with this solution, and one half of the contents injected beneath the skin. This would give 5 milligrammes of the salt at each dose, but making allowance for the liquid remaining in the nozzle of the syringe, and the few drops which are always lost, we may estimate that by this process 4 milligr. (gr. $\frac{1}{18}$) are made to penetrate beneath the cutis.

The first injection was made on the 23d February, and from that date to April 25, the patient received 31 injections upon the sides of the thorax, about the scapular and axillary regions. No lesion was determinable at the site of these injections beyond a slight and transitory induration. The effect of this treatment was perceptible by the time of the 8th injection. About that date we noted the almost complete disappearance of the tubercles situated upon the right naso-labial sulcus, while those upon the scalp became more pale, were depressed, and less segregated.

The retrogressive course of the frambœsia continued, proportioned to the treatment pursued without the local use of any remedy whatever. Only toward the conclusion of the case, when there could be no doubt whatever respecting the influence of the measures employed, the hyperplasia was lightly pencilled with tincture of iodine, in order to hasten its complete resorption. On the 29th of April, the patient was dismissed from the hospital, completely cured of the disorder of the scalp, and presenting no other local affection.

We think we are not in error in concluding that this case is noteworthy, not only on account of the peculiarity and rarity of the disease, but also on account of the speedy therapeutical effects of the hypodermic medication. In our opinion, this course deserves great consideration in the treatment of syphilis, especially in hospitals, for the following reasons: 1st, the administration and dosage of the remedy can be managed with the greatest precision; 2nd, the total and immediate absorption of the drug is rendered certain; 3d, the localized evidences of the dyscrasia, which are often dangerous, can be made to disappear with greater rapidity, and 4th, positive advantages are obtained from the use of mercurials which when given in other ways, for reasons which are not readily appreciated, seem to have no efficacy.

* A gramme of corrosive sublimate can be dissolved in 18 cub. centimetres of distilled water when cold, and in two when warm. A gramme of distilled water dissolves perfectly 0.055 of corrosive sublimate.

Digest of Literature.

I.

DISEASES OF THE SKIN.

ANATOMY, PHYSIOLOGY, AND PATHOLOGY.

A. R. ROBINSON, M. D.

1. **Caspary, J.**—On the anatomy of the hard and soft chancre. *Vierteljahr. für Derm. u. Syph.*, III jahrg., I Heft. 1876.
2. **Ferrari, Primo.**—On cancer in general and in relation to syphilis, scrofula and tubercle. *Perugia*, 1875.
3. **Fischer, Ernest.**—On the structure of Meissner's tactile corpuscles. *Archiv. für mikros. Anatomie*. Bd. XII, 3 Heft. 1876.
4. **Geber, Eduard.**—On the anatomy of erythematous lupus. *Vierteljahr. für Derm. u. Syph.*, III jahrg., I Heft. 1876.
5. **Jacobson, Louis.**—On the influence of skin irritants on the temperature of the body. *Archiv. für path. Anat. u. klin. Med.* Bd. 67, 2 Heft. 1876.
6. **Mojsisovics.**—On the termination of the nerves in the epidermis of mammalia. *Sitzungsber. d. Kais. Acad.* Bd. LXXI.
7. **Unna, P.**—Contributions to the histology and development of the human epidermis and its dependants. *Archiv. für mikros. Anatomie* 12 Bd. 4 Heft. 1876.
8. **Walkenstein, A. V.**—On the influence of skin irritants on the secretion of urine. *Archiv. für path. Anat. u. Phy. und für Klin. Med.*

DR. CASPARY (1) examined microscopically three cases of indurated chancre, and believes the essential difference in structure between hard and soft chancres consists in that in the hard chancre there occurs a connective tissue new growth which does not occur in soft chancres on account of the continual breaking down process which takes place in the latter. In recent cases of indurated chancre, the new growth shows itself as a dense, thick network which surrounds the cells, and in older indurations as entire fibre bundles which separate the cell new growth. We cannot, however, accept conclusions based on the study of only three cases. It would have been better if the author had waited until he had more thoroughly studied the subject before publishing his paper.

DR. FERRARI'S (2) pamphlet contains very little that is original. It is principally a repetition of accepted ideas, without any contribution to disputed questions. He regards cancer as a local epithelial new-formation, having no analogy with syphilis or scrofula. It is not a blood disease, and attacks the blood only by disturbance of general nutrition, and particularly of the functions of the emunctory organs.

The transportation of cancer, he says, takes place by means of the veins, their walls becoming perforated at the seat of origin by the cancerous cellular elements. We would like to know if he has ever seen those active cellular elements being transported. He does not consider cancer contagious, though he has seen a case of cancer of the penis on a man whose wife had cancer on the uterus. As regards its relation to tubercle, he says, they have the same origin, viz., they arise from epithelial cells, but in cancer there is atrophy of the connective tissue and in tubercle there is irritation of this tissue leading to the production of young cells with low vitality, and incapable of organization.

Notwithstanding the careful study to which the tactile corpuscles have so frequently been subjected by capable observers, the real nature and manner of arrangement of its elements still remain an unsettled question. To discover the manner of the termination of the nerve within the corpuscle is not only a difficult task, but has as yet, never been done. We know of no agent or agents, that will render the corpuscle—minus its nerve portion—transparent, and leave the latter intact. Osmic acid, chloride of gold, and other agents which have been used in the study of the tactile corpuscles, have been of more or less service in elucidating certain points; but before the nature of their structure and arrangement is settled beyond question, new methods of examination will be necessary. According to FISCHER (3) the nerve passes into the corpuscle without its mark sheath and here runs in a winding manner, being covered only in places with mark substance. During its windings it divides and probably terminates in different places within the corpuscle in swollen ends? Thus, he says, the nerves terminate in a certain manner, without having any other ground for his view than supposition. The nerves, he says, in their windings in the corpuscle never maintain the same thickness throughout, being sometimes large and sometimes small. The thickened parts are of different forms, round, oval, or spherical, and bent in different shapes. These enlargements are not, as has been supposed, nerve terminations. He does not think the corpuscle is limited by a special membrane, but he lacks the proof. He believes the ground substance is a continuation of the connective sheath of the nerve, hence it has a connective tissue nature. As regards the transverse lines, the nature of which prove such an enigma to microscopists, he cannot give any decided opinion, but thinks that besides coming from the windings of the nerve fibres, they arise also from a linear appearance of the ground substance from foldings of the latter. He denies the elastic nature of the horizontal lines or that the

corpuscle contains elastic tissue. The nuclei belong to the ground substance. The whole subject requires a more exhaustive histological study than it has hitherto received.

Lupus has certainly received a fair share of attention within the last few years. We hope there will be no abatement in the study of skin diseases with the microscope until we have learned something more definite than at present of the changes which take place in the skin and "general cell infiltration, and cell infiltration especially along the back of the bloodvessels" will cease to be given as the special pathology of every disease.

DR. GEBER'S (4) observations, whilst confirming those previously made by Dr. Thin, add to our previous knowledge of the subject and dispel some of the older views. He finds the principal changes in erythematous lupus take place in the upper layer of the cutis, which changes are visible on the margin of the eruption in the greater prominence of the blood vessels of the papillæ and corium. The whole process, he says, takes its origin in the vessels of the papillæ and corium. The first changes in the vessels are coeval with the commencement of the disease. There is an accumulation of blood corpuscles in the vessels and in the tissue. These changes, he believes, are a part of the process and not an artefact, as the corpuscles are seen changed in many ways, the bloodvessels are irregularly distended by them, and pigment cells or their remains are found, together with decolorized red blood corpuscles in the neighborhood. The cell elements of the capillaries undergo many changes, the protoplasmic body becomes larger and more granular, thus lessening the calibre of the vessel. Later on changes showing active proliferation take place in the endothelium of the vessels. The tissue in the papillæ and corium becomes changed to a fine meshed network by the collection of granulation cells. By increase of the elements the papillæ become larger and the malpighian cones smaller. The gland-like excrescences sometimes seen in this disease are due to the lengthened papillæ. The hair follicles become affected only where the afferent vessels are changed and the surrounding tissue filled with round cells. New gland portions are sometimes formed (?) That new gland portions are formed from the sebaceous glands we cannot believe, as what Dr. Geber represents in his drawing as such, is a common normal condition. When the process reaches deeply, he says it does so by the large bloodvessels, and from them the neighboring tissue and the organs imbedded in it are affected. Here either the fixed elements increase or the granulation cells accumulate and destroy the tissue. These cells also undergo fatty degeneration.

The observations of MOJSISOVICS (6) were made on the hairless skin of the central portion of the snout of the swine. The nerve fibres enter the epidermis from the cutis and form the papillæ. Some of them go winding to the surface of the epidermis, becoming smaller and varicose as they approach the upper layer. Some pass downwards and anastomose with other fibres. The fibres that go towards the horny layer bifurcate, but do not anastomose.

They pass between the cells, and some appear to end in club-shaped swellings.

UNNA's (7) contributions cannot be condensed (the article is 77 pages in length) but will repay a careful study.

WALKENSTEIN (7) experimented on rabbits with different irritating substances, some of which acted lightly, and others were powerful irritants. He obtained the following results:—

1. Temperature rose rapidly and remained as long as albuminuria was present and the irritation kept up.

2. Pulse and breathing were increased.

3. Quantity of urine was diminished.

4. There was absence of appetite and thirst.

5. More urea was excreted.

6. The chlorine rapidly diminished; but if the animals eat, the quantity increased again.

7. The animals lost flesh.

8. The urine contained albumen, and sometimes epithelium, lymph corpuscles; by application of cantharides, blood and even casts. Mild irritation produced only slight albuminuria.

9. Mild irritation produced hyperæmia, and stronger irritation parenchymatous inflammation of the kidneys.

10. From the strong irritants, all the internal organs became hyperæmic.

11. Salves, such as ung. hydr., never produced hyperæmia. The albuminuria, he thinks, was produced by increased blood pressure and change in the walls of the vessels of the kidney.

After irritation from electrical current he noticed—

1. Immediate increase of temperature, pulse and breathing, which soon became normal again.

2. Urine and urea increased, especially immediately after irritation.

3. Chlorine was diminished.

4. There was slight albuminuria, which disappeared in from 3 to 6 hours.

NEW FORMATIONS.

EDWARD WIGGLESWORTH, JR., M. D.

1. **Althaus, J.**—Further observations on the electrolytic dispersion of tumors. (*Weitere Beobachtungen über die electrolytische Behandlung der Geschwülste*). Berl. Klin. Wochensft., 17 April, 1876.

2. The Same. Brit. Med. Jour., Nov. 13, 1875.
3. Hebra. Atlas der Hautkrankheiten. Heft. X.
4. Neftel, W. B.—Electrolytic treatment of malignant tumors. Med. Record, N. Y. Mar. 4, 1876.
5. Walckow.—New formations about the navel. (*Beitrag zur Casuistic der Nabelneubildungen.*) Berl. Klin. Wchnsft. XII. —39. 1875. Schmidt's Jahrb. Bd. 169, No. 2, 1876.

The most important contribution to our knowledge of the New Formations of the skin, which has appeared since our last report, is indisputably the tenth part of Hebra's (3) Atlas of Skin Diseases. This contains beautiful plates of Rhinoscleroma, Cheloid, Lymphangioma tuberosum multiplex, Sarcoma Melanodes and Carcinoma melanodes, the last being especially worthy of notice as representing probably the most remarkable case on record.

6. Bergh.—Cases of molluscosis fibrosa. Hospitals Tidende, Apr. 12, 19, 26, 1876.
7. Cordova.—Fr. Observaçion de un caso di Molluscum. Chronica medico-quirurgico de la Habana.
8. Ford, De S.—Fibromata of the skin, with woodcuts. Amer. J. of the Med. Sciences, July, 1876.
9. Rankin, F. H.—Polypoid tumor of left labium majus. Amer. J. of Obstetrics and Diseases of Women and Children, Feb. 1876.
10. Fourestie, M. H.—Fibromes molluscoides multiples. Clin. Chirurg. de la Pitié. L'Union med. XVII. Feb. 10, 1876.
11. Wigglesworth, E.—Fibromata of the Skin and Sub-jacent tissues; with heliotype. Archives of Dermatology, Apr. 1876.

FORD (8) reports a remarkably well pronounced case of fibroma molluscum, occurring upon a negro. The case is accompanied by two woodcuts and illustrates well the enormous size, to which this lesion may attain.

12. Church, W. S.—Heredity of certain forms of xanthelasma of the lids. (*Ueber Erblichkeit gewisser Formen von Xanthelasma der Lider.*) St. Barthol. Hosp. Reports, x. p. 65, 1874. (Schmidt's Jahrb. 169, 2, 1876.)

13. Foot, A. W.—Case of general xanthelasma planum associated with chronic jaundice. Proceedings of the Path. Soc. of Dublin: Dub. J. of Med. Science, May, 1876.

CHURCH (12) asserts that, out of several hundred cases of women of forty years of age and upwards, examined in the St. Bartholomew Hospital, there was coloration of the eyelids present in but eight cases, and in but three of these true xanthoma. Heredity of the macular form of xanthoma has, according to Church, the following reported history in its favor. A first generation consisted of three sons and five daughters. The eldest brother was not affected. He had three daughters, the eldest of whom, late in life, was attacked by xanthoma. Her children and grandchildren, and those of his other daughters

never suffered from the disease. The second brother had xanthoma of the lids. He had no children. The third brother died young. No report of xanthoma is made. The eldest sister had xanthoma. She had no children. The youngest sister had the disease. This one had five children, and one of these was affected. The second sister was free from the evil and her children also, but it appeared upon a grand-daughter. Neither the fourth sister, nor her children, nor her grand-children manifested the lesion. Altogether, of five male members of the family, above forty years of age, but one, of twelve female members in advanced life, five were affected. All descendants of the family, dying young, failed to manifest the new formation. A number of those still living had reached the age of thirty to forty years, without any appearance of the disease.

Foot (13) bases his communication upon xanthoma on an extremely interesting case. It is accompanied by a good chromo-lithograph, and will well repay perusal. It cannot receive justice within the brief space at our disposal. A married woman aged forty-one years and weighing 106 lbs., had been deeply jaundiced for three years. The xanthoma had been present about nine months and its development had been unattended by any local pain, heat, swelling or abnormal irritation. The urine was of the color of porter. Stools usually whitish and bowels constipated. General pruritus, but no xanthops. The process affected both eyelids, the angles between the ears and cheeks, the mucous membrane of the mouth, the neck over the thyroid cartilage, the folds and lines of the palms and the flexures of the phalanges of the toes. The patches were cream colored, pliant, satiny in feel, irregular in outline, abruptly defined, slightly raised and gave the impression of plaques resulting from an aggregate of flattened papules. No vascularity, desquamation, or alteration of sensibility. In thirty cases collected by Hebra and Kaposi, icterus was present fifteen times. Foot has no treatment to recommend. Hebra uses the dermal curette or scraping spoon with good results. The lesion pathologically is a connective tissue new growth within the corium. The coloration is due to fatty degeneration. Some observers regard these changes in the skin as histologically identical with those found in the early stages of atheroma.

14. Beard, G. M.—Electrolytic treatment of nævi. Proceedings of the Med. Soc. of the County of Kings, Brooklyn, N. Y., July, 1876.

15. Bergmann, E.—Treatment of nævi. (*Zur Behandlung der Gefässgeschwülste.*) Dorpat. Med. Zeitsch. VI. Heft. 1 (Allg. Med. Centr. Z'g. Apr. 1, 1876.)

16. Bradley, S. M.—Large veno-cutaneous nævus treated successfully by repeated injections with carbolic acid. Brit. Med. J., Apr. 8, 1876.

17. Brochin.—Deux exemples remarquables de nævi vasculaires. Gaz. des Hôpitaux, 29 Avril, 1876.

18. **Cartaz.**—Des Angiomes ; par R. Virchow. T. IV. Ier Fascic ; (Rev. des Sciences Méd. 15 Juillet, 1876, p. 88).

19. **Duncan, J.**—The treatment of nævus. Edinb. Med. J. Feb., 1876.

20. **Hoggan, F. E.**—Three venous nævi successfully removed by means of the elastic ligature. Med. Examiner, June 29, 1876.

21. **Squire, B.**—On Port Wine Mark and its obliteration without a scar. Essays on the treatment of Skin Diseases, No. III. Lond., J. and A. Churchill, New Burlington St. Also Archives of Dermatology, July, 1876.

22.—Extirpation of nævi followed by the growth of malignant tumors. N. Orleans Med. and Surg. J., May, 1876.

BRADLEY, (16) reports the case of an infant of eight months, with a nævus of the ear $2\frac{1}{2}$ by $1\frac{1}{2}$ inches in superficies, and raised half an inch above the level of the skin. Carbolic acid was injected according to Lister's method. The base of the tumor was transfixed with hare-lip pins at right angles, and the mass strangulated by a ligature to avoid embolism. Five minims of the pure acid were injected here and there in divided doses. After three weeks (six injections) the tumor began to decrease and continued so to do though no more injections were used. Recovery was complete at the end of three months. The stained skin had regained its normal color, which induced Dr. Bradley to try tattooing with carbolic acid for the removal of simple capillary nævi or mother marks. One, of the diameter of half a crown, thus treated, was cured by the end of the third week. A subcutaneous syringe without a piston was used for the tattooing. Dr. B. promises further trials and reports.

DUNCAN, (19) considers that the natural course of nævi, if let alone, is to retrograde, about one-third at the period of the first dentition, with a further marked diminution at the second period of dentition and again about puberty. If not, the dangers are, I. deformity, II. ulceration, III. hæmorrhage, IV. passing into the allied condition of cirroid aneurism. A nævus stationary previous to puberty, is not necessarily permanent and needs no treatment, but, if spreading, interference is called for. Electrolysis by means of uninsulated needles has a very limited application. Electrolysis by means of insulated needles might be regarded as our best means of curing nævi, but that it is more tedious than injection, and less certain than ligature. The needle is insulated by means of vulcanite. It is generally necessary to etherize. The galvanic cautery, but for the cumbrous and costly apparatus required, would supplant the seton and subcutaneous ligature, because it is not attended by suppuration. Excision, ligature or ablation, may either one, be employed. They necessarily leave a scar, but the cure is certain. Subcutaneous injection of coagulants, such as the perchloride of iron, or carbolic acid, may cause sloughing and even death, but, properly used, is safe, very successful and leaves no scar.

23. **Adler, H.**—Conjunctivitis luposa. Allg. Wien. Med. Z'g. No. 20, 1876.

24. **Carafi.**—Observation sur un cas de stéatomes ganglionnaires par infection, à la suite d'une traiteinent d'une loupe du cuir chevelu par les caustiques. La France Méd., 1875, No. 63. (Centr'bl. f. d. Med. Wissensch., No. 3. Jan. 15, 1876.)

25. **Clark, F.**—Tubercular lupus of the tongue, soft palate and gums. Path. Soc. of Lond. Lancet, Nov. 20, 1875.

26. **v. Colomiatti.**—Histologie des Lupus. Annali Univ. di Med. e Chirg., Nov. 1875. (Centr'bl. f. Chir., No. 6, 1876. Allg. Med. Centr. Z'g. 19 Feb., 1876. Lond. Med. Record, Apr. 15, 1876.)

27. **Geber, E.**—Zur Anatomie des Lupus erythematodes. Mit Tafeln, Viertelj. f. Dermat. and Syph., 1876, III. I Heft.

28. **Lang, E.**—Zur Histologie des Lupus (Willani) II Theil. Med. Jahrb. [Stricker's] Jahrg., 1876, I Heft.

29. **Nacy et Figueet.**—Esthiomène de la vulve. Arch. gen. de Méd., Mai., 1876.

30. **Thoma, R.**—Anatomische Untersuchungen über Lupus, Arch. f. path. Anat. u. Phys. u. f. klin. Med. 65 Bd. III Heft. 1875.

COLOMIATTI [26,] Geber [27], Lang (28) and Thoma (30) have furnished most valuable papers upon lupus, of exceeding interest to the specialist but perhaps too scientific, too technical and too confined in scope for immediate practical benefit to the general physician.

31. **Bell, J.**—Anæsthetic leprosy of the left arm. Edinb. Royal Infirmary. Lancet, p. 420, Sept. 18, 1875.

32. **Carter, V.**—Histology of leprosy. Path. Soc. of Lond. Med. Examiner. Vol. I., No. 20, May 18, 1876.

33. **Duckworth, D.**—A case of morphœa. Clin. Soc. of Lond. Med. T. and Gaz., Mar. 11, 1876.

34. **Fox, T.**—Clinical lecture on morphœa. ["Addison's keloid."] Lancet, June 10, 1876.

35. **Kobner.**—Ueber die Lepra an der Riviera nebst Bemerkungen zur Pathologie der Lepra überhaupt. Viertelj. f. Derm. und Syph. III. Jahrg. I. Heft., 1876.

36. **Langhaus.**—Zur Casuistic der Rückenmarks-affectionen (Tetanie und Lepra anæsthetica). Virchow's Arch. LXIV., p. 169.

37. **Lavison, R.**—Note sur le lèpre dite elephantiasis des Grecs ou léonine. La Tribune Méd. No. 401, Apr. 23, 1876.

38. **Mitroy, G.**—Is leprosy contagious? Lond. Med. T. and Gaz., June 19, July 17, Nov. 27, 1875 and Jan. 29, July 22, 1876.

39. "**Mucor.**"—Is Leprosy contagious? Med. T. and Gaz., May 13, 1876.

40. **Neumann, I.**—Ueber die Etiologie der Lepra. Allg. Wien. Med. Z'g., Mar. 7, 1876.

41. **Profeta.**—Récherches sur le lèpre en Sicile. Annales de Derm. et de Syph. T. VII., No. 4, 1875-6.

42.—Lépre nostras tuberculeuse, tachetée et anæsthésique. *Ibidem*, p. 284.

43. **Wernich.**—Notiz über Lepra anæsthetica in Japan. *Virchow's Archiv*, Bd. 67, I. Heft, 1876.

Fox, (34) gives a carefully observed case of the rare disease, morphœa, and distinguishes it from the cheloid of Alibert, but not from the keloid of Addison. Had true Cheloid always been properly spelled according to its derivation by Alibert, as shown by Dr. Hilton Fagge, no confusion need ever have resulted. Fox holds that a real relationship exists between the condition known as morphœa and that, once called keloid of Addison, but at present, more properly designated as Scleroderma. He distinguishes true morphœa also from the whitish anæsthetic patches occurring in the anæsthetic form of leprosy, to which patches Neumann has applied the name of morphœa, and holds that it is an independent malady quite distinct from leprosy.

"MUCOR," (39) an anonymous writer from Melbourne, Victoria, contributes an interesting hypothesis of causation for leprosy. He suggests that the destructive changes of the tissues in leprosy are caused by a mycosis and that the specific micrococci concerned in the mycosis are the direct descendants of a mildew occurring in fecal and perhaps other organic matter, placed under certain conditions of heat, moisture and light. It is assumed that the parts involved in leprosy are infiltrated by colonies of micrococci.

NEUMANN, (40) regards lepra, elephantiasis Græcorum or leprosy, as probably hereditary but not contagious, and influenced by climate and other, more or less hygienic, surroundings; as endemic in certain localities, especially islands and coast lands; as inherited rather from the father than from the mother; as more frequent in man than in woman; as capable of skipping one or more generations and then reappearing; as of rare occurrence prior to the age of six years and usually showing itself only after puberty, but, if previously, then interfering with sexual development; as not primarily occurring after the age of forty years. If the disease could be acquired, it of course might occur at any age after puberty, but it shows itself before this age as the rule when it is inherited. To prevent such transmission, it is the custom in Iceland to tie the vas deferens of the child affected or even, in Scotland, to perform castration. The prognosis in leprosy is unfavorable. Where relapses occur at intervals, the patient lives from six to twenty-four years or more under change of climate and other conditions. The anæsthetic form causes death in from sixteen to twenty-four years, the tubercular within nine years, often from pyæmia resulting from absorption of the matter of softened tubercles. Danielssen lays stress upon the resemblances between leprosy and tuberculosis, and gives as the cause of death in 113 cases of Leprosy; Marasmus, 50; Phthisis, Pneumonia, 13; Bronchitis, 4; Suffocation, 8; Meningitis, 5; Diarrhœa, 15; Ascites, 4; Albuminuria, 3; other complications, 11.

44. **Ashby, T. A.**—Epithelioma of tongue, removal of.

Arch. of clin. Surgery, Vol. I., No. 2, Aug., 1876, p. 78.

45. **Behier.**—Epithelioma de la peau; érysipèle consécutif. Clin. méd. de la Faculté (Hotel Dieu) L'Union méd., No. 65, 1 and 3 June, 1876.

46. **Benson J. S.**—Epithelial cancer of the internal ear. Canada Lancet, 1 Apl. 1876.

47. **v. Buhl (Munchen.)**—Case of general miliary carcinosis. Ein Fall von allgemeiner miliarer Carcinose. Ärztl. Int. Bl., No. 46, 1875. Allg. med. Centr. Z'g., 20 Nov., 1875.

48. **Dauve.**—Epithéliome ulcéré de la base de la langue et du pharynx. Bull. et Mém. de la Soc. de Chir. de Paris, T. II., No. 3, p. 202, Apr. 5, 1876.

49. **Fagge H.**—Carcinoma lipomatosum. Path. Soc. of London. Lancet, p. 665, Nov. 6, 1875.

50. **Fredat.**—Cancroïde consécutif à un psoriasis lingual. Bull. et Mém. de la Soc. de Chir. de Paris, Tome II., No. 3, p. 209, Apr. 5, 1876.

51. **Heath C.**—Epithelioma of the tongue and lower jaw. Path. Soc. of Lond. Lancet, p. 664. Nov. 6, 1875.

52. **Heath, C.**—Three cases of extensive epithelioma, involving the lower jaw; removal by section of the bone and the galvanic écraseur. Univ. Coll. Hosp. Lancet, p. 128, Jan. 22, 1876, and p. 170, Jan. 29, 1876.

53. **Holderness.**—Epithelioma of the arm, developed on the cicatrix of a burn. Huntingdon Co. Hosp. Lancet, p. 207, Aug. 9, 1875.

54. **King, K.**—A case of congenital hard cancer of the leg in an infant. Lancet, p. 766, Nov. 27, 1875.

55. **Lang, E.**—Ueber den flachen Hautkrebs und die ihn vortauschenden Krankheitsprocesse. Wiener Klinik, Mai-Juin, 1876, II. Jahrg.

56. **Parker, W.**—Excision of the umbilicus for malignant disease. Arch. of Clin. Surg., Vol. I., No. 2, Aug., 1876.

57. **Rothmann.**—Condurango in Carcinomen. Corresp. Bl. f. Schweizer Aerzte, 15 Jan., 1876. (Allg. Med. Centr. Z'g., Feb. 16, 1876.)

58. **Stroganow.**—Ueber eine Complication von Elephantiasis Arabum mit Krebs und über die Entwicklung des letzteren. Aus dem Path. Inst. zu Strassburg. Virchow's Arch., LXV., p. 47. Centrbl. f. d. med. Wissensch., Feb. 12. 1876.)

59. **Thin, G.**—On some of the histological changes found in cancer of the skin, or epithelioma, with special reference to the source of the newly-formed epithelial cells. Royal Med. and Clin. Soc. Lond. Lancet, Apr. 1, 1876.

60. **Trelat.**—On the connection of epithelioma of the tongue with psoriasis of that organ. Tribune Méd., Dec. 19, 1875. (New York Med. Record, Mar. 4, 1876. L'Union Méd., No. 25, Feb. 29, 1876.)

61. **Wagstaffe.**—Cancer of both breasts in a male. Lancet, Nov. 6, 1875.

62. **Wier, R. F.**—A rare form of cancer of the penis. *Amer. J. of the Med. Sciences*, Apr., 1876.

63.—*Eucalyptus Globulus* as a cancer remedy. *Southern Med. Record*, June, 1876.

64.—Rhino-plasty for papillary epithelioma. *N. Y. Path. Soc. N. Y. Med Record*, Aug. 5, 1876.

65.—Epithelioma of tongue. *Univ. Coll. Hosp. Reports. Med, T. and Gaz.*, Jan, 29, 1876.

66.—Carcinoma. *Balt. Physician and Surgeon*, Oct. 1875.

THIN (59), in several cases of epithelioma of the lip, prepared sections from the tumors, placed when fresh in osmic acid. He regards this mode of preparation as affording results superior to those obtained from any other method of hardening. His preparations showed the gradual development, step by step, of epithelioma from white blood corpuscles, just as, according to Rindfleisch, epithelium may be regenerated from lymphoid cells.

67. **Croft.**—Sarcoma of the breast. *Path. Soc. of London. Lancet*, p. 664., Nov. 6, 1875.

68. **Gowers.**—Development of spindle cells in nested sarcomas. *Royal Med. and Chir. Soc. Lancet*, Apr. 22, 1876.

69. **Horteloup.**—Telangiectasic sarcoma, etc. *La France Méd.* p. 441, July 10, 1875.

70. **Simpson.**—Sarcomata; their source, structure and relation to neighboring groups of tumors. *Lond. Obstet. Record*, Feb., 1876. (*Detroit Rev. of Med. and Pharm.*, June, 1876.)

71. **Tripier, R.**—Tumeurs multiples présentant les caractères histologiques du sarcome. *Lyon Méd.*, July 16, 1876.

72. **Winiwarter, A.**—Malignant lymphoma and lympho-sarcoma, with special reference to their treatment. *Arch. f. Klin. Chir. Bd. xviii, 1 Heft.* p. 98, 1875. (*Virginia Med. Monthly*, Aug., 1876. *Schmidt's Jahrb. Bd. 169, 1*, 1876.)

73.—Sarcoma of thorax. *N. Y. Path. Soc. ; Med. and Surg. Reporter*, p. 386, May 13, 1876.

74.—The man with a tail (?). A remarkable case of sarcomata (Keloid). *Am. Med. Weekly*, July 1, 1876, p. 7.

75. **Gillette.**—Lipome de la région thoraco-abdominale gauche. *Soc. de Méd. de Paris. L'Union Méd.* No. 35, May 23, 1876.

GILLETTE (75) communicated to the Paris Society for Med. Observation the case of a lady aged 26 years from whom he had removed a lipoma, obtaining union by first intention. The points were,—(1) the advantages of local anæsthesia; (2) the facility of enucleating such tumors through quite small incisions; (3) the union by first intention in spite of effused blood; (4) the slight traumatic icterus; and, finally, (5) the utter ignorance of the writer in regard to the properties and action of ether.

76. **Allen, M.**—Notes on a case of adenia or generalized hypertrophy of the lymphatic glands, followed by wasting inanition and death. *Lancet*, p. 238, Feb. 12, 1876. *Schmidt's Jahrb.*, No. 5, 1876.

77. **Bessey, W. E.**—Lymphadenoma. *Canada Med. Record*, Mar., 1876.

78. **Bessey, W. E.**—Removal of a lymphoma from the right side of the neck. *Canada Lancet*, May 1, 1876.

79. **Biesiadecki.**—Leukämische Tumoren der Haut und des Darmes mit einigen Bemerkungen über den leukämischen Process selbst. *Stricker's Med. Jahrb.*, 1876, III Heft.

80. **Drake, N. A.**—Adenia, with report of cases. *Chicago Med. J. and Examiner*, June, 1876.

81. **Engelsted, S.**—Des néoplasmes lymphatiques de la peau. *Nordiskt Med. Arkiv.*, Bd. vii, H. iii, No. 15. (*Rev. des Sciences Méd.*, July 15, 1876.)

82. **Haward, W.**—Lymphadenoma. *Clin. Soc. of London. Lancet*, p. 880, Dec. 18, 1875.

83. **Katser, S.**—Ueber Drüsengeschwulste und deren Behandlung. *Wien. Med. Presse*, May 7th, 14th, 28th, 1876.

ALLEN (76) reports a case of lymphoma well worthy of mention. W. L., aged 29, a marine, cachectic looking, entered the Naval Hospital of Plymouth, Eng., June 14th, for dyspepsia. Two weeks later the chest and limbs were discovered to be dotted with small, hard, painless, glandular swellings, which, according to the patient, had existed for six weeks. He had been operated upon by ligature, in the previous December, for a nævus over the right clavicle. By July 1st the dyspepsia was gone, but he was detained in the Hospital by the increasing size of the tumors, some of which had become very painful. July 20th. Losing flesh and appetite; swellings increasing in number, their integument inflamed and threatening ulceration. Aug. 30. Worse. Sept. 4. A fit, succeeded by periodical attacks and syncope until Sept. 17th, when he was allowed a furlough for change of air. Re-admitted Oct. 20. Reduced in appearance; complains of nausea and vomiting; the tumors are now scattered over the whole body, following the lines of the lymphatics, the integument of many of them having a purplish color; darting pain from the left temple to the occiput, causing loss of sleep. Oct. 21. Gastric irritability. Oct. 26. Two more tumors appeared. Oct. 29. Sensations of extreme cold. Nov. 12. Several painful tumors upon the back, excised to give relief from pain. Dec. 1st. Sight of the left eye impaired from the pressure of a tumor. Dec. 14. There are now 47 tumors in all; patient nearly blind; great thirst; on the left buttock a tumor as large as a hen's egg; pulse 136, small and weak; temp. 99°; body attenuated; ptosis of right eye; intellect, for the first time, impaired; he gradually grew worse, and died Jan. 5. The autopsy showed enlarged spleen; kidneys pale and flabby; the left ureter occluded by a cheesy calculus; three or four mesenteric glands enlarged, indurated and loaded with calcareous deposit; the largest solitary tumor was in the left breast; the conglomerate tumors reached their maximum bulk in the right axilla; the nodules on section were firm and whitish, mottled with dark gray spots. The microscope showed a "highly hypertrophied gland structure," with several caudate cells, apparently cancerous.

HEMORRHAGES AND NEUROSES.

ARTHUR VAN HARLINGEN, M. D.

1. Alexander, R.—Purpura hemorrhagica. Case. Lancet, Vol. I, 1876, p. 776.
2. Guibout, E.—Purpura. La France Méd., p. 525, Aug. 12, 1876.
3. Hale, J. J.—Purpura. Cincinnati Clinic, May 13, 1876, p. 231.
4. Hayem.—Purpura hemorrhagica, with autopsy. Soc. de Biol. Le Progrès Méd., July 8, 1876, p. 507.
5. Hebra, F. von.—Purpura. Death from cerebral hemorrhage. Kais. Könige. Gesells. f. Ärzte., 876, No. 19. Gaz. Hebdom., May 22, 1876.
6. Kurtz, Edgar.—A case of morbus maculosus Werlhofii, with menorrhagia. Memorabilien, Feb. 9, 1876, p. 529.
7. King, E. W.—Case of purpura hemorrhagica treated by ergotine hypodermically. Am. Jour. Med. Sci., April, 1876, p. 593.
8. Richardson, J. B.—Ergot in purpura hemorrhagica. Louisville Med. News, Feb. 5, 1876.
9. Trend, H. G.—Purpura rheumatica. Case. Proc. Clin. Soc. Med. Times and Gaz., Vol. I, 1876, p. 240.
10. Whittaker.—Purpura variolosa, with stenosis of the larynx. Trans. Cin. Acad. Med. Cincinnati Clinic, Jan. 8, 1876, p. 19.

ALEXANDER'S (1) case was carefully noted as regards temperature, etc., during life, and a thorough examination made *post mortem* showed the usual purpuric patches over the various viscera, and notably the heart, an unusual locality. None were found in the intestine.

HEBRA (5) read before the Imperial Society the notes of a case in which sudden death occurred in a young man suffering from purpura. The *post mortem* examination showed steatosis of the arteries of the brain, with rupture and consequent cerebral hemorrhage. A very interesting discussion (given in the *Gaz. Heb.*) followed, during which phosphorous poisoning was suggested as the cause of death. No phosphorous had been found, however, after careful examination.

TREND'S (9) case was that of a youth of 17, who, after being in poor health for several months, suffered an attack of tonsillitis. Upon the subsidence of this, painful swelling of several of the joints ensued, preceded by a distinct rigor and accompanied by an

eruption of purpuric patches on the arms and legs. The treatment consisted of rest, with the administration of perchloride of iron. In the course of the discussion on this case at the Clinical Society, Dr. A. A. Stewart lauded the virtues of lemon juice, which he had used in a similar case with very good effect.

11. **Black, J. R.**—Pruritus pudendi. Chloral as an anti-pruritic. *Cincinnati Lancet and Obs.*, March, 1876, p. 230.

12. **Burnett, C. H.**—Three cases of tinnitus aurium and deafness, accompanied by very distinct flushing of the cutaneous surface adjacent to the ear. *Archives of Ophthal. and Otology*, Vol. IV., 1875, p. 503.

13. **Cordon—Fenelon.**—On generalized neuromata. 8vo. p.p. 48, Thèse de Paris. *La France Méd.*, Jan. 15, 1876, p. 37.

14. **Dejerine, J.**—Alterations in cutaneous nerves in a case of pemphigus occurring in the course of general paralysis: lesions of the cord and extremities of the nerves. *Arch. de Phys. Norm. et Path.*, May–June, 1876.

15. **Folsom, N. L.**—Treatment of pruritus. *Phila. Med. and Surg. Reporter*, March 25, 1876.

16. **Gelle.**—Good effects of the hydrate of chloral in topical applications for pruritus vulvæ. *La Tribune Méd. La Presse Méd.*, Belge, Jan. 23, 1876.

17. **Gill, H.**—Treatment of pruritus vulvæ by nitrate of alumina. *St. Louis Med. and Surg. Jour.* (Phila. Med. and Surg. Reporter, May 27, 1876.)

18. **Hutchinson, Jonathan.**—On winter prurigo. *British Med. Jour.*, Dec. 25, 1875, p. 773.

19. **Hardy.**—Treatment of cutaneous hyperæsthesia. *Le Progres Méd.* 1876, p. 446.

20. **Jones, C. Hanfield.**—Cases of obscure nerve disorder. Herpes zoster, followed by severe neuralgia and considerable motor paralysis. Benefit from galvanization. *Med. Times and Gaz.*, Sept. 1, 1876.

21. **Ory, E.**—Treatment of cutaneous hyperæsthesias. *Le Progrès Méd.*, June 17, 1876, p. 466.

22. **Pirnat, John.**—Treatment of pruritus hiemalis. *Phila. Med. and Surg. Reporter*, Jan. 29, 1876.

23. **Simon, Oscar.**—Pruritus (prurigo) hiemalis. *Centralbl. f. Med.* 1876.

24. **Wills, Saml. E.**—Pruritus in pregnancy. *Phila. Med. and Surg. Reporter*, May 6, 1876.

25. **Wiltshire.**—Pruritus vulvæ. *Brit. Med. Jour.*, V.I. 1876. p. 323.

26. **Winniwarter, A. von.**—Changes in skin resulting from plexiform neuromata of arm. *Archiv. f. Klin. Chirurg.*, Bd. 19, 1876, p. 595.

BLACK (11) suggests the topical application of chloral, 3 iii. ad aquæ, 3 iv., to be employed every hour until relief is obtained.

DEJERINE (14) examined the cutaneous nerves in the neighborhood of the bullæ of pemphigus occurring in the course of general

paralysis. He found very evident signs of alteration, the nerve tubules being diminished in diameter at some points and swollen at others, an appearance due to segmentation of the myelin, which instead of being continuous, was broken up into sections giving the tubules a moniliform aspect. The sheath of Schwan which was retroverted, contained protoplasmic matter coloring yellow with picrocarmine. The nuclei were not abnormally multiplied. As to the cylinder axis, it had completely disappeared; and, in fact, the whole appearance resembled that presented by the peripheral portion of a nerve 15 or 20 days after section (plates are given).

FOLSOM (15) after trying all kinds of remedies without success in an obstinate case of pruritus vulvæ of pregnancy, finally had recourse to essence of peppermint locally applied which acted very favorably.

GILL (16) recommends in pruritus vulvæ the application of nitrate of alumina. It has, in his hands, given more satisfaction than any other remedy. He employs a solution of 4 to 6 grains to the ounce of soft water, to be used as a vaginal injection or external wash once or twice a day if necessary.

HUTCHINSON'S (18) "winter prurigo" is the well known affection, pruritus hiemalis first described by Duhring. (Phila. Med. Times, Jan 10, 1874. Abst. in ARCHIVES OF DERM. V. I., No. I, p. 81.

PIRNAT (22) recommends the following treatment in pruritus hiemalis. $\mathcal{R}$ Zinci sulphat, $\mathfrak{z}$ vi.; Ammon muriat, $\mathfrak{z}$ ivss.; Aquæ pluvialis, Oiv. ad vj. M. Wash the body all over, morning and evening. In connexion with this stimulating and astringent wash he prescribes an alterative-laxative pill, and an alterative-sedative and demulcent mixture.

SIMON (23) claims priority for Handschuh (Allg. Zeitschr. f. chirurg. No. 23, 1844) over Duhring and Hutchinson in the description of pruritus hiemalis.

WILLS (24) suggests the following treatment in the pruritus of pregnancy. $\mathcal{R}$ Sodii borat, $\mathfrak{z}$ ss.; Morphiae sulph., grs. vj.; Aq. ros. dest, $\mathfrak{z}$ viii.; M. Sig. Apply 3 or 4 times a day after washing with soap and water, and drying. A. G. W., in the same journal suggests the following: $\mathcal{R}$ Ung. spermaceti, $\mathfrak{z}$ i.; Hyd. chlor. mite., $\mathfrak{z}$ ss. adj.; Ext. Bellad. $\mathfrak{z}$ i. Sig. M. Anoint several times a day after washing the parts in carbolized water.

PARASITIC DISEASES.

HENRY G. PIFFARD, M. D.

I. VEGETABLE.

1. **Aubert.**—Two cases of herpes tonsurans occurring in persons under treatment for favus. *Lyon Méd.*, Aug. 27, 1876.

2. **Beck.**—Notes on a case of tinea tonsurans. *Lancet*, Oct. 16, 1875.

3. **Dien.**—On the contagion of herpes circinatus from the horse to man. *Gaz. des Hôp.*, Apr. 1, 1876.

4. **Ladreit de Lacharriere.**—Notes on the treatment of tinea tonsurans. *Bull. Gen. de Thérapeutique*, Aug. 15, 1876.

5. **Lailier.**—Trichophytie. *Gaz. des Hôp.*, Nos. 19, 23, 25, 1876.

6. **Lespian.**—Treatment of the trichophyton. *La France Médic.*, 1876.

7. **Lynch.**—Case of ringworm occurring in an infant within six hours of birth. *Med. Press and Circ.*, March 22d, 1876.

8. **Tipple.**—Case of ringworm. *Lancet*, July 29, 1876.

9. **Wilson.**—Treatment of ringworm. *Medical Examiner*, Apr. 6, 1876.

AUBERT (1) bases his diagnosis of herpes tonsurans in three cases, upon the fact that the affected hairs were infiltrated with spores; he succeeded in inoculating the affection upon the arm of one of his *internes*, the hairs becoming infiltrated. He failed to inoculate the disease upon rats, in which it is usually easy to inoculate favus but not herpes tonsurans.

LADREIT DE LACHARRIERE (4) in ringworm employs a cosmetic stick composed of Croton Oil, butter of Cacao and white wax. The mixture contains 50 per cent. of the oil. He fails to give precise directions for its use, but reports good results, curing his cases in from six weeks to two months.

LESPIAN recommends (6) a mixture of Tannin, 1 part; Tr. Iodine, 10 parts; and Glycerine, 20 parts, to be applied twice a day to patches of trichophytic disease.

In LYNCH's case of ringworm in an infant (7) the child was born at 2 P.M. In the evening a small red spot was noticed upon the right cheek, three-quarters of an inch below the eye. It steadily increased in size, and twenty days later had attained a diameter about an inch, and was clearly recognized to be a ringworm. It was then ascertained that the nurse, four days previous to the birth of the child, had visited some friends where one of the children was suffering from ringworm. The remarkable feature of the case, is that the trichophyton should have within a period of six hours, multiplied to such an extent as to attract attention.

10. **Tuckey.**—Contagious impetigo. *Practitioner*, September, 1876.

TUCKEY, appears (10) to have encountered the true impetigo contagiosa of Fox, and relates the histories of several cases which fell under his observation. He arrives at the opinion, that the disease is contagious and inoculable, "and that it is capable of being transmitted from one to another through the medium of vaccine lymph." He also inclines to the belief that the affection is caused by a parasitic fungus, but states that he has not seen this idea suggested in any of the works which he has consulted. (It may be remembered that in 1873, the present reviewer contributed two articles to the *New York Medical Journal* on the subject of Impetigo Contagiosa; in one of which the opinion was expressed that the affection was parasitic, and in the other that it was in some way connected with vaccination.)

11. **Carter.**—Mycosis of the Skin. *Lancet*, Aug. 28, 1875.

CARTER, in the microscopical examination of "Bouton de Biskra," found microcci and filaments, from the ends of some of which conidia seemed to be given off.

12. **Kemper.**—Podelcoma. *American Practitioner*, September, 1876.

KEMPER says (12) "Podelcoma, from *πους*, a foot, and *ελκωμα* an ulcer is a malady affecting the feet, and sometimes the hands, of the inhabitants of intertropical countries; and known by various names, such as Madura foot, fungus disease of India, etc."

The extreme rarity in this country of the affection described by the author, warrants an extended notice. The patient, a young man 24 years of age, consulted Dr. K. in May 1876, stating that about the middle of the previous December, his right foot became swollen, reddened and painful, and in three weeks the entire sole of the foot was so tender that he could bear no weight upon it. Subsequently blebs formed, and enlarged until they attained a diameter of half an inch. The cuticle, which was of a dirty white color, was intact, except at the centre of each bleb where a round opening existed with well defined borders. From these openings there daily exuded about half an ounce of glairy fluid resembling the white of an egg. By enlargement of the openings veritable ulcers were apparent, which by increase in size became confluent. The whole foot was exquisitely painful. Various local measures failed to give relief, and the pain ultimately became so intense, and uncontrollable that, amputation was performed. *Microscopical examination.* The surface of the ulcer was covered with a whitish, fluffy substance, presenting to the naked eye the appearance of a mould or fungus. The ulcers were the opening of sinuses which burrowed among the muscles and deeper tissues of the foot, but not reaching bone. Portions of the deeper muscles were found disintegrated, giving place to masses of mould-like material, which was found to be composed, under a magnifying power of 200 diameters, of numerous granulated bodies, which were rough and irregular in outline, yellowish in color and strongly refractile. The author considers that those bodies are vegetable spores. (This

case, whether it be one of genuine mycetoma or not, is, I believe, unique so far as this country is concerned, H.G.P.)

13. **Kaposi.**—The present standpoint in regard to the vegetable parasites of the human skin. Rundshan, May 1876.

14. **Remy.**—Researches on the microscopic anatomy of favus. Bull. de la Soc. Anat. 3. 1875.

II. ANIMAL.

15. **Mailhetard.**—Contribution à l'étude de la gale. Paris 1876.

16. **Risel.**—Statistics of scabies. Berl. Klin. Woch. July 10 1876.

17. **Perry.**—Pediculophobia. The Med. and Surg. Reporter April 1, 1876.

18. **Da Silva Arango.**—Memoria sobre a filiarose ou a molestia produzida por una nova especie de parasita cutaneo. Bahia 1875. Rev. des Sci. Méd., July 1876.

ARANGO describes (18) an affection peculiar to Brazil, and hitherto unnoticed. It is produced by a nematoid worm which he proposes to call the *Filaria dermathemica*. The egg of the filaria penetrates the glandular orifices of the skin and acts as a foreign body, producing the inflammation which characterizes the disease. The lesions may be papular, vesicular or vesiculo-papular, but never pustular. The pruritus is intense. The affection somewhat resembles scabies but may be distinguished by the absence of *sillons*. Treatment by carbolic acid is recommended.

II.

SYPHILIS AND VENEREAL DISEASES.

GENERAL QUESTIONS IN SYPHILIS, THERAPEUSIS, ETC.*

R. W. TAYLOR, M. D.

1. **Ambrose.**—Concealment of venereal diseases in the Army. British Med. Journal, July 24, 1875.

2. **Anonymous.** Early history of syphilis. British Med. Journal, Jan. 23, 1875.

3. **Boeck, Wm.** Researches on Syphilis, etc. Acad. des Sciences, La France Méd., p. 569, Aug. 30, 1876.

* Portions of this Digest have already appeared in the columns of the N. Y. Medical Record.

4. **Bollinger, Dr.**—Syphilis in the hare. Virchow's Archives, Band. LIX, Heft. 384.
5. **Cadell.**—Simulated syphilis. Medico-chirurg Soc. of Edinburgh,—The Med. and Surg. Reporter, July 1, 1876.
6. **Charpy, Adrien.**—On the periods of acquired syphilis. Annales de Dermat. et de Syph., Tome VI, No. 1, p. 20.
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The pathology of syphilis was selected as the subject for a lengthy discussion at the Pathological Society of London, and to Mr. JONATHAN HUTCHINSON (11) was assigned the duty of preparing and reading the introductory address. The debate, including the opening and closing papers, occupied nearly five sessions of the Society during the months of February, March, and April, of this year. Although we must confess our disappointment in the matter as a whole, we feel it our duty to present our readers with a general synopsis of it, as many eminent men expressed their views upon points which are treated of in this department. The readers of the ARCHIVES have already been presented with Mr. Hutchinson's paper in full (in the issue of April, 1876, p. 231), but it is necessary to here give its main points, in order that a proper understanding of the views of the speakers may be had.

We certainly think that the council of the society showed good judgment in selecting Mr. Jonathan Hutchinson as the person to open the debate, and further, that he has in the main performed his task well. At the outset, however, we must express our disapproval of the statement so emphatically made at the commencement of the paper, in which Mr. Hutchinson says: "I think we may say of dualism that it is dead, and that the now simpler creed which attributes the soft chancre to contagion with inflammatory products produced by syphilis, but not as a rule containing its germs, is the one which obtains general acceptance. We have, then, in syphilis, but one malady and one virus." We think this statement is for various reasons ill-judged. As dualism is not one of the distinct issues of his paper, he should not thus curtly allude to it and dismiss it, as by so doing he opened the way to irrelevant discussion, and at the same time rendered himself liable to mislead those who are not familiar with the minute aspects of the question. Clinically, to-day, the fact that the hard sore always produces syphilis, and that the soft sore does not, but that it is simply local in its operation, is as generally received and as susceptible of overwhelmingly convincing proof, as it was when it was so boldly advocated by Bassereau twenty-odd years ago; and the fact, or rather the statement, that this local or soft sore is related more or less remotely with syphilitic inflammatory processes, while in a measure it modifies the dualistic view in a theoretical way, has no practical effect upon it,—certainly it does not demolish it. Hence we think that the allusion made by Mr. Hutchinson was ill-judged and misleading in its effect, particularly so if his words are carefully weighed; for he says that the soft sore may not, as a rule, contain syphilitic germs; the inference is plain that sometimes then it may, when, of course, syphilis would follow. We judge from the whole tenor of his remarks that he does not really think that this is the case.

As is well known, Mr. Hutchinson has been one of the most ardent advocates of the view that syphilis is a specific fever, having definite stages, with periods of incubation, and of the outbreak of the efflorescences or exanthems, followed by sequelæ, which are

generally called tertiary lesions. These opinions he here reiterates, and devotes much space to prove that tertiary lesions are not direct effects of the disease, but rather results or sequelæ of it. His argument in support of this opinion, which by the way was severely criticised, is that in the early stages of syphilis the manifestations are general and symmetrical, thus proving, he thinks, that it is then a blood disease ; but that after a greater or less lapse of time, they are unsymmetrically developed, which fact goes to prove that they are not any longer manifestations of a blood disease, but on the contrary, as we have said, sequelæ of it. He thinks that the same feature is observed in the course of the exanthemata. Mr. Hutchinson thus expresses himself : "In all probability syphilis ceases to be a blood disease when symmetrical manifestations cease to be usual. This period varies according to the treatment adopted and the idiosyncrasy of the patient." As to the date at which syphilis is no longer contagious, Mr. Hutchinson truly says that negative evidence goes to prove that this is the case in the tertiary period, and adds that the power of hereditary transmission may remain long after this cessation. Practically, this point is of great importance. As instances of the local lesions or sequelæ, the author cites the relapsing affections of the tongue and skin, and thinks that the fact that these are amenable to local treatment, is in a measure proof that they are not real manifestations of the disease. He further suggests that perhaps local treatment would also cure the internal gummata, if they were likewise accessible. He does not think that Lancereaux simplifies the question of periods by calling the tertiary stage the period of gummy deposits, as such are sometimes found even in the secondary stage. He admits that these secondary gummata are not dissimilar from those of the later period. This opinion appears very singular, when compared with the statement that tertiary gummata are sequelæ.

He then considers the peculiarities of syphilitic inflammations, and the relation of the various lesions histologically the one to the other, which he considers very intimate. In the first category he calls attention to the immunity generally possessed by syphilitic growths to suppuration and at some length speaks of their tendency to produce phagedena and sloughing, as well as in some instances to undergo interstitial absorption. As to syphilis being the cause of phagedena, he expresses himself more strongly than any authority with whom we are familiar, as he says : "So marked is the liability to phagedena in syphilis, and so rare in connection with any other cause, that, with few exceptions, we may count syphilis either directly or indirectly as the parent of all phagedena." Reverting again to that still unsettled question, the periods of syphilis, Mr. Hutchinson very forcibly states, that attempts to found a division of the secondary and tertiary stages by a tendency or otherwise to deep ulceration only add confusion to the subject. We think, however, that he fails to make clear his position as to the distinctly marked differences in these periods. His chief reliance is upon the symmetry of the secondary stage, and the absence

thereof in the tertiary. He carries this idea to the extent of saying that if rupia is symmetrically developed it is a secondary manifestation, while if not symmetrical it is tertiary, there being no peculiarity of the lesion to settle the question. Though in some instances this may be true, there are so many exceptions to the statement that it should not be unreservedly received. In speaking of symmetry and asymmetry of eruptions, Mr. H. makes a remark which is certainly at variance with his position, that it is a *question of abundance* rather than of character, which really means that in the secondary stage the infiltrations are copious, and scanty in the tertiary. Finally, as regards differences between secondary and tertiary lesions, he states that the former undergo spontaneous resolution, while as a rule the latter do not. Foreseeing that it may be urged that in the secondary period the more superficial tissues are the ones generally involved, and then only in a superficial way; and that in the tertiary stage deep ulceration takes place and deep tissues are involved—says that he can only admit, with great limitation, these assertions, as the ulcerative processes are often severe in the secondary stage; and that we do not know definitely that the viscera are not involved in the secondary period.

This leads him to offer a suggestion of much practical value, namely, the necessity for study of the effect of syphilis in its early or secondary stage upon the viscera. He clearly shows, by numerous examples, that in this stage other tissues than the more superficial ones are affected. This portion of the paper is both interesting and suggestive. Further, he advances the hypothesis that tertiary lesions may really be only the result of secondary ones, they developing themselves in tissues upon which secondary lesions have stamped a morbid impress. This suggestion is worthy of attention, though abundant evidence can be cited against it. It is, as Mr. H. says, different from the theory advanced by Virchow, that tertiary lesions and relapses are due to the syphilitic poison stored away in lymphatic glands, and from them bursting forth and thus involving blood and tissues. Passing, then, to the consideration of hereditary syphilis, he sketches in a general way its course, and alludes to its more prominent features. He thinks that in this form we do not, as a rule, meet the well-marked tertiary lesions of the acquired variety, such as cellular tissue gummata and lesions of the muscles and tongue. In children we have less frequently nervous phenomena than in adults; and in them is to be observed, as a rule, a more marked limitation of the disease; so that, although a child may suffer for years with lesions of inherited syphilis, its future life will usually be free from syphilitic manifestations.

Mr. Hutchinson is very explicit in his statements as to the relation of syphilis and scrofula, and thinks that the manifestations of both conditions are markedly distinct the one from the other, and that they possess no pathological relation with one another. We must express our surprise that Mr. H. does not acknowledge that

syphilis may act as a predisposing cause to the production of scrofula. To our surprise he, we think unnecessarily, considers the relations between lupus and syphilis, but very properly concludes that none exist. The paper ends with a grateful acknowledgment of the labors of the various living observers upon syphilis.

Such is a general outline of Mr. Hutchinson's paper. It may, perhaps, conduce to a clearer idea of the points made by the various speakers, by presenting the main arguments in an aphoristic form, as follows:—

1st. That syphilis is a blood disease, being in fact a specific fever, arising only from contagion, having prolonged but tolerably definite stages, and being manifested by more or less general eruptions.

2d. That the symmetrical distribution of the early lesions favors the view that they are due to a blood state, and that syphilis ceases to be a blood disease at the end of the secondary stage.

3d. That tertiary lesions being unsymmetrical and not due to a blood cause, but that they are chiefly sequelæ, developed in the tissues in consequence of some morbid impress left by lesions of the secondary period.

4th. That it is probable that in the secondary stage there are visceral lesions of which we know little or nothing.

5th. That the course of hereditary and acquired syphilis present well marked differences. In the former there is often an absence of the early manifestations and there is not seen in it those large gummatous infiltrations seen in the acquired disease.

6th. That there is no pathological relation, simply a casual one between syphilis and struma and lupus; but that phagadema is most generally caused by syphilis.

MR. HENRY LEE did not believe that syphilis ceased to be a blood disease at the end of the secondary period, and thought it was not supported by facts. He spoke in a vague manner, as to three distinct forms of "primary affection," but leaves us wholly at a loss to know what the forms are, and what affection he refers to. Unless this gentleman's remarks are carelessly and too curtly reported, they are without exception the most indefinite of those of any participant in the discussion. We refer our readers to the original report with the hope that they can grasp his meaning.

DR DRYSDALE spoke in favor of dualism, a topic only incidentally alluded to by Mr. Hutchinson, therefore not exactly pertinent to the debate. He also regarded syphilis as belonging to the exanthemata, but thought that tertiary lesions were evidence of a blood state. He spoke of a case in which right hemiplegia followed by permanent aphasia appeared coincidentally with roseola. He had observed jaundice in the secondary stage, thought that the liver was often involved early in syphilis, and had often seen the development of nodes, a few months after infection; acquired syphilis in children rapidly passes away, and he had never seen tertiary lesions develop in such subjects. He had never

observed nervous symptoms in inherited syphilis, but had frequently seen gummata. He thought that only a casual relation can exist between syphilis and scrofula. He had been informed in Paris by Verneuil and Fournier, that they did not observe interstitial keratitis frequently in children and that they believed it to be caused by scrofula and not by syphilis.

The debate was formally opened at the second meeting by SIR JAMES PAGET, whose remarks are, taken as a whole, disappointing. He agreed with Mr. Hutchinson that in syphilis we have one disease due to one virus, being in fact a specific fever with periods of incubation, general eruption followed by certain sequelæ. He agreed with the orator as to the nature of these sequelæ, and endeavored in a long and desultory argument to establish analogies between those of syphilis and those of other fevers. It would profit the reader nothing to have this portion of the speech condensed. The similes offered in support of the view that tertiary lesions are due to local morbid impress produced by earlier lesions were weak if not simply absurd, particularly that of the leech bites, and we make this remark with a due appreciation of the great knowledge of the speaker. The remarks upon the relation of syphilis to gout, tuberculosis and scrofula were interesting. Sir James thinks that the soil in which the syphilitic poison is sown, in other words the peculiarities of constitution have an influence in causing the varying appearance and course of the lesions. Strange to say, Sir James confounds the two varieties of venereal sore, though he thinks there is but one virus.

DR. WILKS remarked that there is no disease like syphilis in our nosology, but that it is a counterpart of the febrile affections. Without offering any better division, he rejects that into the primary, secondary and tertiary stages. He thinks that visceral lesions occur in the secondary stage, and has observed that when they do occur early, there is frequently an absence or slight development of cutaneous manifestations. He has observed that the infiltrations of syphilis did not as a rule, suppurate, and that even when fluctuation was felt complete absorption might be induced. He endeavored in a labored argument to draw an analogy between syphilis and small pox, but really did not add one idea to our stock of knowledge. He concludes his remarks, which occupy four closely and finely printed columns of the *British Medical Journal*, with the statement that, to his mind, the lesions of syphilis and scrofula were distinct and readily recognisable the one from the other.

The remarks of DR. HILTON FAGGE were noticeable for their comparative brevity, a quality in general foreign to the discussion under consideration. He alluded to the point overlooked by Mr. Hutchinson, namely, the relation of syphilis to amyloid or lardaceous degeneration. According to Dr. Fagge, syphilis and prolonged suppuration are the only causes of this condition, and so strong is his opinion upon this point that he states that if at post-mortem he finds no evidences of suppuration, he is confident that

the patient was syphilitic. He evidently thinks that syphilis has no specific action in producing this degeneration, but that it is caused by the debilitating influence of the disease upon the general nutrition. He thinks that the lesions of the lungs in syphilis are caused in the same way, and that they are due to diffuse inflammatory changes, rather than to a definite or specific morbid growth. He holds the view that syphilitic eruptions are specific and readily recognizable, and that simple eruptions may exist on the skin of syphilitic subjects without being modified or losing their essential characteristics, even when the patient is subjected to anti-syphilitic treatment.

MR. BERKELEY HILL'S remarks were general in character, and fortunately not prolix. He thinks syphilis is a blood disease from first to last, and transmissible even in the later stages to the offspring. He further lays stress on the fact that children who have inherited syphilis from parents afflicted with tertiary or late syphilis, may communicate the disease to others, such as their nurses, in its most active and typical form, as being a powerfully affirmative argument. The fact that late lesions require for their cure anti-syphilitic remedies, is regarded by him as being proof that they are similar in nature to the earlier ones, which are undoubtedly due to a blood state. He thinks that Mr. Hutchinson attaches too much importance to the significance of symmetry of distribution of eruptions, and that in syphilis they are generally less symmetrical than in the other more acute diseases. He says the body generally is covered with an eruption in the early stages; this is succeeded by a more circumscribed rash; and lastly, this fades away until there may be one, two, or three patches on either side of the body. This statement, which is based on observations really places the matter in a simple and intelligible form; it is really the practical illustration of the question of abundance alluded to by Mr. Hutchinson, but by him explained, as we know, in another way. Mr. Hill expressed himself quite clearly as to the variations in the type of the disease. He fully endorsed Sir James Paget's view, that the soil in which the virus is implanted is mainly the determining cause of the course of the disease; but added that perhaps the source of the contagion might also exert an influence. Thus he was disposed to think that the disease might be severer in its course when derived from a person in whom it was in an active form, and lighter when the contagion was waning in intensity. He did not accept the dictum of the orator that dualism is dead.

Mr. Hill was followed by MR. DE MERIC, whose remarks were terse and pointed. Without entering into a consideration of the doctrine of dualism, he asserted his belief that it was well founded. As to the analogy between syphilis and the specific fevers, he thought it perfectly correct with certain modifications as to variola only, and hinted that as regards the others, it was somewhat forced. In his experience phagedena was an exceptional occurrence, rather than the usual one; and he did not go as far as Mr.

Hutchinson in saying that it was always due to syphilis. He adhered to the division into the stages, or periods, which are generally recognized; and hinted that Mr. Hutchinson had not simplified the matter by considering the disease as having but one stage and sequelæ. He thought that the symmetry spoken of by the orator did not exist as widely as it was claimed it did; and that it was impossible to place, as the latter wished to do, every lesion in mathematical order. Tertiary lesions showed a decline in the disease, hence they were the results of a blood state. He differed with Sir James Paget as to the simile of the leech-bites. Although Mr. De Meric did not express himself distinctly, it is to be inferred from his remarks that he thinks that syphilis may predispose a patient to the development of struma, and that both conditions give rise to different and recognizable lesions.

DR. BROADBENT'S remarks were, on the whole valuable and pertinent, but lengthy. He differed from Mr. Hutchinson in certain points as to the course of infantile syphilis. He had seen gummatous infiltrations into the tongue and skin in subjects of this disease, an occurrence, if not denied, yet considered very improbable by Mr. Hutchinson. He alluded to the fact referred to in the opening, that two subjects of congenital syphilis had died in consequence of granular kidney, which condition, was thought by Mr. H., to be due to the use of iodide of potassium. He had seen a case in which such a complication was observed, and being in doubt as to its causation, suggested that data bearing upon it should be produced. He alluded to the fact that the evidences of hereditary syphilis disappeared quite completely in time, and that subjects of the disease enjoyed average good health. He evidently leans to the opinion that when amyloid disease is found in early life it is due to this disease. Taking up then the question of the nature of gummata, he differed from some other speakers in thinking that those of syphilis are specific, and that those of the exanthemata are not so, citing thrombosis, necrosis, catarrh of the middle ear, and the parotid bubo of typhus, which may be due to other causes than the specific fevers. He cited the fact alluded to by Mr. Hill, that severe tertiary often followed mild secondary lesions as tending to show a specific character of the former. Strangely enough he pronounced himself as an advocate of the old theory, now renounced even by its former advocate, Mr. Hutchinson, that a woman could be infected by syphilis from a fetus, and become more syphilitic by each pregnancy. He came to this conclusion from the observation of cases of nervous affections in mothers who confess to have had syphilitic children, and by seeing the disease in a more intense form during and after each pregnancy. It is evident that he had not in these cases clearly traced out the regular course of the syphilis.

The next speaker DR. BUZZARD, as might be expected, touched chiefly upon the nervous phenomena of the disease, and briefly gave some interesting facts. He thinks that the frequency of occurrence of nervous troubles in secondary syphilis has been un-

derrated. Of one hundred cases of brain syphilis cited by him the average age of the patients was thirty-five. In eighty-three cases the date of infection was ascertained, the nervous phenomena supervening after five years in fifty-six, and within that period in twenty-seven. In short, in one-third of the cases the nervous system was involved within five years of infection. The supervention of nervous trouble in the eighty-three cases was as follows: below five years, 27 cases; between five and ten years, 23; ten to fifteen, 25; between 15 and 20 years, 6; 20 to 25 years, 2. Of the twenty-seven cases in which the troubles came on within five years, six occurred under two years, four under three, six under four, and eleven between four and five years; the affections being hemiplegia, convulsive disorders and paraplegia. Optic neuritis was not observed under three years, but in the one hundred cases occurred fifteen times; in twenty there was paralysis of orbital muscles; in five disseminated choroiditis, and old iritis in two cases. The symptoms of the early nervous affections did not present any marked peculiarity from those of the later ones; they were of the order of vaso-motor irritation, such as disposition to fainting, contraction of retinal vessels, large pupil and acceleration of the heart. He had seen mental symptoms, in some cases almost maniacal, in early syphilis. He coincided with the hint thrown out by Mr. Hutchinson as to the relation of tertiary lesions to the secondaries through tissue change induced by the latter, and suggested that perhaps this occurred through the medium of the lymphatic system. He cited instances showing a tendency in syphilis for lymphatic canals and bursal sacs to be involved.

SIR WM. JENNER, did not think that the manifestations of all acute diseases were symmetrical, nor that symmetry of distribution was necessarily an expression of blood disease. He thought that there were sequelæ of acute specific diseases which were in nature specific, and cited as an instance the paralysis of diphtheria which was undoubtedly the result of blood disease. He evidently thinks, though his remarks were so terse and brief that we judge so only from their general tenor, that most of the so-called sequelæ of the exanthemata are really "mere accidental disturbances of nutrition." Thus far in the argument this is the only time that this aspect of the question of the nature of the sequelæ of the various affections has been broached, and it is to be regretted that it was not considered in all its bearings, as it is really vital to the question of the simile to determine really which are sequelæ of these exanthems and which merely, as very properly called, accidental disturbances of nutrition. The remarks of Sir William upon the pathology of infantile syphilis showed that he had studied closely into its nature, and we regret that he did not express himself at greater length and with more precision. He thinks that the sperm cell contains the infecting element of syphilis; that this body contains, as he terms it, "the potentiality of development," and that its chief and primary action is in the tissues, while the blood is secondarily involved.

In contrast with the admirable contributions of Sir Wm. Jenner,

the remarks of Dr. MOXON are noticeable for their tedious prolixity and their sophistical character. We must express both our surprise and disappointment at this effort of a man, who, by his writings upon visceral syphilis, has heretofore commanded our highest respect. In fifty-six observations of visceral syphilis, he had found the average period of life to have been thirty-seven years, and his experience had taught him that in such cases the prognosis was not good, as the future of such patients was a short one. He differed from Mr. Hutchinson's view as to the non-specific nature of tertiary lesions, and considers that the necessity of mercury for a total cure of them proves them to be related to the secondaries. He emphasized the admission of the orator that the want of symmetry of tertiaries was really due to the condition of abundance; and considered that this, in truth, conceded the relation of both classes of lesions. While he agreed with Sir. Wm. Jenner that the lesions of typhoid fever were very rarely symmetrical, he did not consider that the comparison offered by Sir James Paget, that such sequelæ of this disease as the suppuration of one rib or of phlebitis of one vein, applied at all to the distribution of tertiary syphilitic lesions. He believed that these latter lesions were often symmetrical, and cited instances of such, the most noticeable of which was that of a gumma involving each root of the vagus. He alluded to the fact that such diseases as pityriasis versicolor and trichiniasis, well known to be unconnected with blood taint, were frequently symmetrical. He further differed with Mr. Hutchinson as to the theory of the possible relation of the secondary and tertiary lesions, which we have previously explained, and advanced the hypothesis that perhaps the latter attacked tissues which had not been affected by the former. In support of this, he ventured an unsatisfactory line of argument; and misapplied, in his comparison, certain well-known facts. Indeed, we hardly think he was sincere in this part of his remarks; as they convey the impression that he thought Mr. Hutchinson's theory, to say the least, untenable, if not ridiculous; and that he might, by way of pleasantry, propound one equally absurd. We must, however, credit Dr. Moxon with a happy and apposite expression in calling syphilis "a fever diluted by time."

The remarks of Mr. THOS. SMITH, who opened the debate at the fourth meeting, were of a personal character and contain no noticeable point. He regards syphilis as a blood disease, and its tertiary lesions as evidences of such, thinks that secondary supplies is not very symmetrical; that the tertiary form was not always unsymmetrical in its manifestations, and did not admit that the risk of contagion ceased long before that of hereditary transmission. The simile traced by this gentleman between the course of gout and syphilis need only be mentioned as being badly taken, and not by any means conclusively proven. This being alluded to, later on by Mr. Simon, Mr. Smith said he wished merely to contrast gout with syphilis.

SIR WM. GULL thought that if syphilis were classed with the

specific fevers it should be conceded that it was not like the rest of them, limited by time. He regarded gummata as specific lesions, and that a general condition of the system was always present with them. He did not care to open the question of blood diseases, but stated his belief, that as there was no tissue in which syphilis might not produce its manifestations, it was, therefore "a flesh and blood disease." This expression of Sir William's is certainly significant and pertinent, and shows that he, as well as Sir William Jenner, look further than the majority of those concerned in the debate, in not being satisfied with the explanation of the nature of the disease on exclusively humoral doctrines. Sir William thought that syphilitic symptoms might continue throughout life, and be found in the hair, the complexion and the odor of the sweat. The last symptom certainly appears to us to be a novel one, as caused by syphilis, yet it was spoken of by this distinguished authority as having been recognized by him, as he says he had under his care a man supposed to be suffering from tuberculosis, who "smelt of syphilis." We would commend to our readers the study of this peculiar odor, as it is a symptom which, if quickly and positively recognized, may be of much assistance in cases of doubt. It is to be regretted that we have not fuller information as to its qualities and characteristics.

As might be expected, the remarks of MR. SIMON gave evidence of a profound knowledge of general and special pathology. He thought that it was impossible to draw an abrupt line between the secondary and tertiary stages of syphilis, and that we were not warranted in considering the disease as no longer one of the blood because the lesions cease to be symmetrical. This condition of asymmetry was probably due to a diminution in the quantity of the contagium, and of course the power was then also weakened. And the offspring of such a person might not be infected; still he would not say because a man had gummata, he could not beget syphilitic children; nor because his lesions were unsymmetrical that he was no longer capable of transmitting the disease to his wife. His remarks upon the nature of sequelæ are striking. He says; "He could not understand such a thing as an active sequela in pathology. A passive sequela, such as a cicatrix, he could understand; but a renewed active growth was surely not, strictly speaking, a sequela. It implied if anything, that the cause of the formation was still in operation." According to his experience, syphilis did not produce or modify other diseases. He neither rejected nor accepted Mr. Hutchinson's view of the origin of tertiary lesions, and hoped that the question could be studied in future whenever opportunity offered. He thought that much benefit might result in the determination of the ultimate results of syphilis by investigations into the family histories, and was undecided as to whether syphilis manifested itself in the third generation.

We might almost pass in silence the remarks of MR. JOHN WOOD, as they were not of much importance. He evidently considers the two forms of sore as due to one virus. He did not consider tertiary lesions as sequelæ, thought that we could not

draw a line of distinction between the two stages of syphilis, and that too much stress had been laid upon the asymmetry of late lesions by the orator. He alluded to the fact, in a inquiring way, of the mild course of syphilis in races among whom the disease had existed for years, and its severe effects when introduced into virgin soil.

There is but little of interest in the brief remarks of the next speaker, SURGEON ROBINSON. This gentleman, in thirty years' experience in the Guards, nearly every man of whom had syphilis, rarely saw evidences of hereditary syphilis in their offspring which condition he attributed to the early and thorough mercurial treatment which they are subjected to under strict surveillance.

MR. E. VENNING called upon Mr. Hutchinson to explain more fully his position as to the question of dualism. He looked upon the soft sore as being placed in a category by itself.

To this view DR. FARQUHURSON expressed his concurrence, and he further agreed with Mr. Hutchinson as regards the resemblance between syphilis and the exanthemata, and also as to the frequency of mild secondary lesions being followed by severe tertiaries. He admitted a syphilitic form of phthisis.

The remarks of the next speaker DR. GREENFIELD, showed an intimate acquaintance with the histological pathology of syphilis supplemented by sound knowledge of its clinical history. His histological results are similar to those of previous observers. In their earliest stages syphilitic new growths consist of lymphoid tissue, mainly composed of round cells, developed chiefly in the outer coat or perivascular space of minute blood-vessels. The growth was at first highly vascular, and was succeeded by the development of an embryonic tissue. The peculiarity of the process was the invasion of the inner coat of the arteries supplying the growth, as so well shown recently by Heubner. This lesion of the inner coat caused or led to thrombosis and degeneration. Subsequently the growth was supplied by new vessels again. This process had been seen by Greenfield in the kidney, and he had also found gummata in the brain in secondary syphilis. He looked upon all syphilitic growths as due to the same cause, and as direct expressions of the syphilitic action, and thought that the resemblance claimed between syphilis and the exanthemata was partial only; and in a concise and clear manner he indicated the pathological differences in the courses of the two classes of disease. He inquired whether Mr. Hutchinson believed that every case of pegged teeth or of interstitial keratitis was one of congenital syphilis, as he believed that in some the condition might be due simply to an inherited tendency to imperfect development, or early decay of the more highly developed forms of connective tissue, which were the expression of the exhaustion of the power of connective-tissue formation. As showing the influence of the parent's condition on such development in the child, he instanced the occurrence of cretinism in children of goitrous parents during their residence in affected districts. He concludes his otherwise very able remarks

by the suggestion that the evidence of the heredity of syphilis was accompanied by the date of occurrence of the specific eruption, which suggested inoculation at the time of birth or at the separation of the placenta. We look with surprise at such views from a man otherwise so sound in his knowledge of syphilis.

The fifth evening was devoted to the remarks of the president of the Society and to the summing up of the orator, Mr. Jonathan Hutchinson.

The remarks of the president, Mr. GEORGE POLLOCK, contained no note-worthy point, being rather a series of interrogatories addressed to the next speaker, rather than a presentation of facts. It is evident that, like that of many of the participants in the discussion, the gentleman's knowledge upon the subject is of a general and practical character, and that he has not paid especial attention to its study. He attributes very little importance to the division of the disease into stages, and is not certain as to the precise period at which its contagion ceases, though he thinks that hereditary transmission is possible in the tertiary stage. He alluded to the fact that surgical lesions of continuity often remained un-united owing to a tertiary syphilitic condition. He did not agree with Sir James Paget as to the sequelæ of fevers, and thinks that those of typhoid are of pyæmic nature and often symmetrical. After congratulating the society upon Mr. Hutchinson's paper and the debate, he called upon that gentleman for his reply.

MR. HUTCHINSON reviewed the various leading points brought out in his opening, and pronounced himself in the most emphatic manner as a believer in the cryptogamic nature of syphilis. Seeing that previously he had not clearly formulated this view, the suddenness of the avowal is somewhat startling. It must be conceded that his course was either wise or lucky, for had this aspect of the question been developed as a feature of the opening, we are not certain where the debate, which was very long indeed, would have ended. Though his opinion is strongly expressed, it is evident that his ideas are by no means mature or clear. His view, that the existence of a syphilitic yeast or *contagium vivum*, as causing syphilis, offers the best and most rational explanation of the phenomena of the disease, is obviously open to the most serious criticism, and shows that he is almost exclusively wedded to the humoral doctrines of pathology, as applied to syphilis. He still thinks that the analogy between the course of syphilis and the exanthemata is well taken, not having been shaken by the remarks of some speakers, which, he says, dealt with opinions rather than facts. He reiterates the statement that, as a rule, syphilis, when uninfluenced by treatment, is tolerably orderly in its course, while that of the exanthems is far from being as regular as we are accustomed to think. We cannot here follow Mr. Hutchinson in his remarks as to the state of the blood as modified by the syphilitic germs, and shall only repeat more precisely the fact that he thinks that the principal processes take place in that fluid, and that the rôle played by the tissues in these diseases is only secondary. It

is readily seen that this view opens the way to extended comment and analysis, such as indeed are precluded by the nature of this notice. It seems strange that, among so many eminent pathologists, the great import of Sir Wm. Jenner's suggestion, that syphilis is a *flesh and blood* disease, was not fully appreciated, and that the doctrines therein embodied did not seem to be familiar to them. It may here be suggested that if the doctrine of a ferment in syphilis is admitted, the analogy between it and the exanthemata must be, to a greater or less extent, conceded; but when it is urged that, perhaps, certain specific proliferative changes take place in the tissues themselves, and that from them, by the medium of the blood, the disease is perpetuated and communicated, the analogy, to say the least, is weakened, and a line of argument is established, which was, as we have shown, only hinted at by one or two speakers, and by Mr. Hutchinson rejected. Indeed we have reason for the suspicion that he did not appreciate the full significance of the train of facts embodied in Sir Wm. Jenner's suggestion. Thus it will be seen that, with this cardinal point unconsidered, nearly all the remarks were a practical concession of the analogy; hence that we are, at the end, exactly where we commenced. We very much regret this result, as the occasion was a rare one, and much could have been said as to the place of syphilis in nosology. It is true that some light has been thrown upon the nature of the sequelæ of certain blood diseases, but as to that of the tertiary lesions we have had little added, other than opinions; so that, in his reply, Mr. Hutchinson expresses his theory as to their simple nature, and as to their being tissue derivatives from pre-existing specific lesions, with more emphasis than he did in his introductory. In this connection we may say that we, for many reasons, wholly repudiate this hypothesis, for we look upon it as simply a theoretical expedient rendered necessary by the doctrine of ferments just considered. Passing now to practical questions, Mr. Hutchinson calls attention to the fact that contagion generally occurs within the first two years of the disease, and that various clinical facts go to show that the blood does not retain its infective properties but for a few years. He allows syphilitics to marry at the expiration of two years after the disappearance of the last syphilitic symptoms. Mr. Hutchinson makes clever use of the germ theory to explain late hereditary transmission of syphilis, by saying that, perhaps, the germs remain latent in the testes and ovaries for a longer period than in the blood. This shows the weakness of the humoral theory, as it is an unequivocal concession that the elements of the disease remain latent in the tissues themselves. It seems curious that an observer of his ability and a thinker of his powers should thus stultify himself to the import of facts which is clearly apparent, merely to preserve the symmetry of a theory. We shall not follow the argument of the orator as to the nature of infantile syphilis, as it is really a piece of special pleading in favor of his yeast theory, with an evident intent of throwing ridicule on the tissue theory, as express-

ed by Sir Wm. Jenner in the term "potentialities of development." It is very clear that Mr. Hutchinson is so far biased by his blood and yeast hypothesis that he cannot or will not admit any other view. The result is to very much impair the value of his summing up. Mr. Hutchinson's remarks upon the effect of a syphilitic fœtus upon the mother, are interesting, if not thoroughly orthodox in their teaching. He alluded to the fact, long ago spoken of by Colles, that women bearing syphilitic children were not by them infected, and stated that no exception had been brought forward. In explanation, he thinks that a modified form of syphilis is given to the woman, in which there is a protection to her from severe manifestations, and which is unattended with cutaneous lesions. He compares its nature to that of vaccination. It will be seen that this is a direct admission from him that the fœtus can infect (though in a qualified manner) the mother. But, further on, he declares himself a believer in the doctrine that syphilis may be derived from the father alone, while the mother escapes, and promises further information on this point. The rest of his reply was simply in answer to certain minor issues raised by the various speakers, and it contains nothing noteworthy or important. Those of our readers who have followed us in our brief presentation of this debate, will see that, while it has suggested many points, much has been left untouched, while some of the direct issues raised by the orator have been left in much the same state as before the debate. We have already exceeded our limits, and cannot now review critically the whole discussion, which was in many parts too long and wordy. We may, however, derive some benefit from its perusal, and we have the satisfaction of knowing that it can be rendered profitable to future debaters on this subject, in pointing out to them errors which they can avoid. In this connection we would remark that it can hardly be expected that a subject like syphilis, which for its thorough discussion, requires special study and observation, can be very minutely handled by men who have only observed it in a general and practical way.

26. **Allen.**—Syphilitic condylomata; syphiloderm. *Phila. Hosp. The Med. & Surg. Reporter*, July 15, 1876.

27. **Charpy, Adrien.**—Syphilitic gummata of the skin. *Annales de Dermat. et de Syph.* Tome VI. No. 1 p. 28.

28. **Duhring.**—Ulcerating syphiloderm resembling lupus vulgaris. *The Med. & Surg. Reporter*, Dec. 4, 1875.

29. **Grunfield.**—Buboes of the elbow. *Wiener Med. Presse*, No. 10, 1876. (*Viertelj. f. Derm. u. Syph.* 1876, p. 282.)

30. **Hardy.**—Pustulo-crustaceous syphilide of the face. *Le Prog. Méd.* p. 577, Aug. 12, 1876.

31. **Hutchinson, James H.**—*Rupia specifica*. *The Med. & Surg. Reporter*, Feb. 5, 1876.

32. **Kolaczek.**—Ein Fall von Frambæsia syphilitica. (*Dermatitis papillaris von Hebra.*) *Deutsche med. Wochenschr.* No. 14, 1876. (*Allg. Med. Centr.* 12th April, 1876.)

33. **Maury, F. F.**—Early forms of syphilis, syphilitic lichen ; chancre and bubo. *The Med. and Surg. Reporter*, June 3, 1876.
34. **Maury, F. F.**—A clinical lecture on tertiary syphilis. *Med. and Surg. Reporter*, p. 81, July 29, 1876.
35. **Oedmansson, Ernst.**—Syphilis and erythema multiforme. *Nord Med. Ark.* vi. I., 1874. (*Schmidt's Jahrbücher*, November, 1874.)
36. **Petters, Wm.**—On the question of the power of infection of vegetations. *Vierteljahresschrift für Dermatologie und Syphilis*, 2 & 3, 1875.
37. **Pirocchi Pasquale.**—Syphilitic discoloration of the skin. *Giornale del Mal. Ven. e della Pelle*, June, 1875.

CHANCRE AND CHANCROID.

38. **Brinton, John H.**—Venereal ulcers. *The Med. and Surg. Reporter*, January 15, 1876.
39. **Brinton, John H.**—Chancre ; phymosis ; paraphymosis. *The Med. and Surg. Reporter*, February 19, 1876.
40. **Cernatesco, J. N.**—Course and duration of syphilitic chancre and vulvar syphilides during gestation. Brochure. Paris, 1875.
41. **Fenwick, Geo. E.**—Strange locations for primary chancres. *Canada Med. and Surg. Journ.* *The Med and Surg. Reporter*, May 27, 1876.
42. **Gross.**—Chancres with phymosis. *The Med. and Surg. Reporter*, January 22, 1876.
43. **Hutchinson, Jonathan.**—Soft chancres in their relation to syphilis. *Lancet*, Sept. 18 and 25, 1875.
44. **Klink.**—A case of tuberculosis of the genito-urinary organs simulating a concealed chancre of the urethra and bladder. "*Medycyna*," Tome III., No. 30, 1870. (*Viertelj. f. Derm. u. Syph.* 1876, p. 283.)
45. **Sains J. A.**—Chancroidal ulcer of glans, complicated with phagedena, cured by the Pollini powder. *Giornale Ital. delle Mal Ven. e della Pelle*, Feb., 1875.

THE TREATMENT OF SYPHILIS.

46. **Bellamy, W. J. H.**—Quinia in osteocopic pains of secondary syphilis. *Virginia Medical Monthly*, Feb., 1876.
47. **Croft, J.**—Serpiginous and phagedenic ulceration and quinine. *St. Thomas Hosp. Rep.*, vol. 5, 1875.
48. **Dickson, H.**—Carbolic acid in syphilis. *Lancet*, p. 309, Aug. 26, 1876.
49. **Keyes, E. L.**—The effect of small doses of mercury in modifying the number of red blood corpuscles in syphilis. *Amer. Jour. of Med. Science*, p. 17, Jan., 1876.
50. **Seeley.**—Treatment of primary syphilis by Lewin's method.

Nashville Jour. of Med. and Surg., Oct., 1875. (Chicago Med. Journ. and Exam., p. 63, Jan., 1876.)

51. **Thompson, J. W.**—The treatment of syphilis, with remarks on the degree of inheritance. Richmond and Louisville Medical Journal, Feb., 1876.

SYPHILITIC DISEASES OF THE EYE.

RICHARD H. DERBY, M. D.

1. **Hock.**—Die Syphilitischen Augenkrankheiten. Wien. Med. Klin., Marz–April, 1876.

2. **Noyes, H. D.**—Syphilis of the eye. Genito-Urinary Diseases with Syphilis, by Van Buren and Keyes, 1874, p. 600.

3. **Bull, C. S.**—Observations on some syphilitic lesions of the eye, with cases. Am. Jour. Med. Sciences, April, 1875, p. 412.

4. **Carter, R. Brudenell.**—Syphilis of the eye, (on some principles of Ophthalmic Therapeutics). St. George's Hosp. Rep., Vol. VII., p. 98. Braithwaite, Jan., 1876, p. 180.

5. **Drognat-Landle**, (Rio Janeiro.) Syphilitic iritis, (de l'iritis syphilitique.) Annales d'oculistique, May, June, 1875, p. 250.

6. **Hutchinson, J.**—Syphilitic keratitis at an unusually early age. The Lancet, p. 876, Dec. 18, 1875.

7. **Friedenwald.**—Diffuse corneitis. Med. and Surg. Reporter, July 29, 1876.

8. **Pflüger.**—Ulcus induratum of the edges of the lids. Klin. Monatsbl. f. Augenheilkunde, Mai, 1876, p. 160.

9. **Pooley, R. T.**—Right sided binocular hemiopia, depending upon a gummy tumor in the left posterior lobe of the brain. Archives of Ophth. and Otology, vol. V. No. 2.

10. **Drouin.**—Study of the syphilitic lesions of the deep membranes of the eye. Brochure, 8° Delahaye, Paris, 1876.

Hock's (1) work is of considerable length, and is a careful resumé of the various manifestations of syphilis in the eye. His conclusions are based in a great measure upon his personal observation. The author finds among all cases of constitutional syphilis, 4 to 5 per cent. of iritis; while among 2,500 otherwise healthy people, iritis occurs in 1 or .04 per cent.

Among the author's conclusions is this: certain affections of the eye have such pathognomonic signs that they may be recognized as specific. These are gumma of the iris, and the opacities which accompany the so-called specific retinitis.

From his own and statistics of v. Arlt, v. Wecker, and others, the author believes that half of all cases of iritis are specific.

In speaking of the usual course of iritis (specific,) the author thinks that the recovery is either complete, and that the iris itself

returns to a normal condition, or small adhesions result between the iris and the anterior capsule of the lens. These adhesions or synechiæ, the author thinks, lead to no farther trouble. With this view we cannot agree. In the adhesion between capsule and iris, we have found a most frequent cause of relapse in cases of iritis, and this view is shared by v. Arlt, v. Graefe, v. Wecker,* and others.

The author insists upon the necessity of treating every case of specific iritis at the outset with mercury.

NOYES (2) Speaks of the diffuse form of keratitis occurring in syphilitic patients between the ages of six months and two years. We think experience shows that this affection in such patients rarely, if ever occurs at this so early age. In reference to this point the paper of Mr. Hutchinson, referred to in this Digest, is of importance.

The author devotes considerable space to the description of syphilitic iritis and its complications. In regard to its treatment he says: "I have no hesitation in stating that the usefulness of either mercury or iodine to cure iritis is exceptional and not the rule." In another passage he says, "I have seen a large number, and indeed, the majority of cases of syphilitic iritis recover without being subjected to any of the so-called specific remedies."

Such absolute statements from a well known author in a popular text book we cannot allow to pass unchallenged. That mercury in nearly all cases of specific iritis is an essential element of treatment, is a well accepted fact, and we believe almost no other author can be found to assert the contrary. Wecker † says, "if we recognize the iritis to be syphilitic the indications are rare when we should abstain from the use of mercury."

Arlt ‡ writes, "in case of syphilitic iritis, the treatment must be as much constitutional as local."

Stellwag § in reference to this affection says; "the constitutional disease must be treated with remedies which act in the speediest and most effectual way."

In Von Graefe's clinical lectures he says; "at one time in the Charité Hospital the experiment was tried of treating all cases of syphilis without mercury. I tried this unfortunate course too in syphilitic iritis, and remarked then the great tendency of these cases to become complicated with choroiditis, opacities of the vitreous and retinitis."

It must not be inferred from what has been said, that the author of this excellent chapter on syphilis of the eye, is opposed to the use of mercury in all cases of specific iritis; he expressly states that under conditions specified, specific constitutional treatment ought to be employed to counteract the poison whose potent influence has induced the iritis.

BULL (3) gives the notes of twenty-seven cases of lesion of the eye,

* v. Wecker, *Traité Pratique*, I, 402. † v. Wecker, *Traité Pratique*, I, 401.

‡ Arlt, *Augenkrankheiten* 2, 270. § Stellwag, *Augenheilkunde*, 245.

occurring in syphilitic patients, the author's conclusions may be given in his own words. "It may be seen from these cases that iritis is not always the first symptom of syphilitic disease of the eye, as in six of them it did not occur at all. We also learn to dread relapses from iritis, as they generally involve the deeper tissues of the eye, and set up choroiditis, or cyclitis, or both, though it is rare to see an inflammation of the optic nerve or retina, as the first lesion of syphilis in the eye, yet we do meet with such cases."

CARTER (4) after discussing the curative effects of mercury and iodide of potash in syphilis is of the opinion that it is in the eye that the immediate curative action of mercury is most remarkable. He draws attention to Dr. Anstie's theory, that mercury has some especial elective affinity for, or special action upon, the parts which are supplied by the fifth nerve, and finds support for this theory in the fact that the poisonous effect of mercury is displayed first upon the gums, which derive their nerve supply from the source indicated. In regard to the question—the choice between mercury and iodide of potash—the writer thinks that the best rule for practice is to inquire whether the local changes in actual progress are such as to inflict irreparable injury unless they are speedily arrested. If they are, then iodide of potash should be given in the first instance. If not, mercury may often be best given first. The author dwells at length upon the importance of the local treatment of eye-disease in cases of syphilis.

DROGNAT LANDRE (5) gives us carefully prepared and judiciously analyzed notes of seventy-two eyes affected by iritis. The author regards the ciliary (episcleral) injection as a constant symptom in all cases of iritis. This symptom is pathognomonic.

In half of the cases here presented, severe pain was caused by pressure upon the closed eye in the upper part of the ciliary region, near the cornea. In these cases of iritis, affections of the cornea were common, both parenchymatous and in the lower part of the membrane of Descemet. Retinitis and congestion of the retina complicated many of these cases, and especially those in which there were changes on the membrane of Descemet.

In regard to treatment the author has little to say. Paracentesis of the cornea has not given him satisfactory results.

HUTCHINSON (6) reports a case of well marked and symmetrical interstitial keratitis of a month's duration in a child of three years of age. The child looked healthy and had a good set of milk teeth, but had been treated in infancy for a long-continued rash and severe snuffles. The interesting point in this case is the unusually early age at which the keratitis occurred. As a rule the syphilitic diffuse keratitis occurs at the age between eight and ten.

FRIEDENWALD (7) describes in a clinical lecture the diffuse form of keratitis. In reference to this form of keratitis in connection with inherited syphilis, and of the importance as a diagnostic mark of the latter of certain peculiarities of the permanent teeth, the author is of the opinion that the notched condition of the teeth (described first by Hutchinson) is met with in many cases

where there is no syphilitic taint ; the author thinks that the connection between congenital syphilis and a notched condition of the teeth is not sufficiently uniform to give to the latter a diagnostic importance.

PFLUGER (8) describes, in the case of a man seventy-two years of age, an at least doubtful case of chancre of the eyelids. Upon the swollen, indurated margin of both lids, throughout nearly their entire extent, was a clearly defined ulcer, involving the conjunctiva of the lower lid. From this there was a thin, white secretion. A few days after treatment was commenced another small, round ulcer, with infiltrated edges, appeared on the cheek below this. The treatment consisted in mercurial inunction and the local use of nitrate of silver and a weak solution of corrosive sublimate. In three weeks the ulcer had healed, and a few weeks later all induration had disappeared. Several facts speak strongly against the correctness of the diagnosis in this case. The true chancre is usually unique and simultaneously multiple ; never multiple by successive auto-inoculation. This patient was seen six months after the first appearance of the ulcer and there were then no signs of constitutional syphilis. The advanced age of the patient does not strengthen the probability of the correctness of the author's diagnosis.

In POOLEY'S (9) case in addition to the hemiopia, there was partial hemiplegia of the right side and some paresis of sensation of the right arm. The patient had aphasia and later an optic neuritis of the left eye. A week after this last he died. At the autopsy a gummy tumor was found in the left posterior lobe of the brain. The chiasma and trunci optici were not changed, and the right hemisphere was normal.

DISEASES AND INJURIES OF THE PENIS, URETHRA-TESTICLE, ETC.

E. L. KEYES, M. D.

1. **Behncke.** Congenital absence of urethra in the female. *Ugesk. f. Læger, and Nord. Med. Arkiv.* Vol. VII, No. 3, (New York Med. Jour., June, 1876, p. 654.)
2. **LeFort.** Imperfect formation of the external genitals. *La France Méd.*, April 22, 1876, p. 253.
3. **Jordon Furneaux.** Injurious results of congenitally small urinary meatus. *Lancet*, Jan. 27, 1876. (Half Yearly Compend. July, 1876, p. 457.)

4. **Siredey and de Sinety.** Incomplete development of genital organs. *Le Prog. Méd.*, Jan. 22, 1876, p. 59.

5. **Stritzer.** Abnormal meatus urinarius in the male. *Viertelj. f. Derm. and Syph.* 1875, 4th Hft. p. 468.

6. **Busch.** Mechanism of the so-called luxation of the penis. *Berl. Klin. Woch.* Sept. 13, 1875, p. 510. (*Rev. des Sci. Méd.* Jan. 1876, p. 271.)

7. **Chenat.** Tuberculosis of the genito-urinary organs—case with autopsy. *Le Prog. Méd.*, Oct. 23, 1875, p. 613.

8. **Chevalereau, A.** Treatment of phimosis, etc. *La France Méd.*, Feb. 5, 1876, p. 82.

9. **Eldridge, S.** Case of Van Buren's disease of the penis. *N. Y. Med. Jour.*, Sept. 1876, p. 260. (The responsibility of naming this disease is due to Dr. Eldridge. It was described by Johnson many years before Van Buren saw a case. Ref.)

10. **English.** On tumors of the spermatic cord in new-born children. *Stricker's Jahrb.* 1875, No. 3.

11. **Gouley, W. S.** Urethroplastic operations. *N. Y. Med. Record*, Feb. 19, 1876, p. 116.

12. **Hamilton, J. B.** Rupture of the urethra. *N. Y. Med. Jour.*, Dec. 1875, p. 616.

13. **Louquet, P.** Priapism in a patient with splenic leukemia. *Le Prog. Méd.*, Aug. 7, 1875, p. 447.

14. **Normand, Eugene.** Phimosis and its treatment. *Thèse de Paris.* *La France Méd.* Jan. 15, 1876, p. 37.

15. **Reudy, H.** Tuberculization of the urinary passages, urethra, etc., case with autopsy, (*Soc. anat.*) *Le Prog. Méd.*, Oct. 23, 1876, p. 612.

16. **St. Germain.** Circumcision. *Le Mouvement Méd.* Sept., 1875.

17. **Teevan.** Laceration of urethra (two cases). *Lancet*, Aug. 21, 1875. Catheter passed and tied in in each case—with good result.

18.—**Fistula of Cowper's gland.** *La France Méd.*, April 15, 1876, p. 237.

BUSCH, (6) explains the mechanism of the so-called luxation of the penis as follows. The integument of the penis is more firmly attached to the abdominal and scrotal integument than it is to the preputial semi-mucous membrane—consequently when an external force (as a wheel) drags upon the scrotum, the integument is all pulled away and tears at the prepuce, while the penis is left behind somewhere in the hypogastric region on one side or the other, according to the direction of the force, if it is downward; or in the scrotum or perinæal region if the direction of the force has been upwards. The same effects follow when the skin of the penis is caught and torn off, separation first taking place at the preputial juncture.

HAMILTON reports (12) a case of ruptured urethra, caused by the passage of the wheel of a cart over the perinæum. Ice bags were applied to the injured point, and the aspirator relied upon

during several days to empty the bladder. The patient made a prompt recovery.

19. **Althaus, Julius.**—Case of nervous disorder, consequent upon gonorrhœa, etc. *Med. Times and Gaz.*, April 8th, 1876.

20. **Bron, F.**—De l'influence exercée sur le moral par les maladies des organes génito-urinaires. 8vo. Lyons, 1875.

21. **Bron, F.**—Urethral neuropathy. *Lyon Méd.*, Sept. 5th, 1875, p. 10.

22. **Chamberlain, W. M.**—Nervous disorders from genital organs. *N. Y. Med. Record*, Dec. 25th, 1875, p. 862.

23.—Genital hypochondriasis. *La France Méd.*, Aug. 11th, 1875, p. 515.

ALTHAUS'S case (19) was one of extreme irritability of the deep urethra, following prolonged urethritis and lighted up just before marriage (probably) by ungratified sexual desire. The pain on intercourse and at other times became steadily worse after marriage, and defied ordinary treatment (no systematic treatment by pressure with steel sound was attempted, however.) A cure was effected in seven weeks by using a mild galvanic current (25 to 35 cells of Becker-Muirhead's battery), passages of the cathode being made over the entire lumbar region, and the anode being placed upon the perineum. He speaks highly of the benefit produced in this case by his inducing in the patient catelectrotonus of the spine.

BRON simply describes (21) neuralgia of the deep urethra and vesical neck, and states his belief in the value of introducing soft bougies every other day, and leaving them in place two minutes. The advice is somewhat too dogmatic to cover all cases; doubtless it often answers well.

CHAMBERLAIN (22) reports a case of urethral irritability leading to such sexual sensitiveness that the patient (a married man) was degenerating into a "flabby erotomaniac." A slight stricture of large calibre was found and freely cut, with the effect of relieving the patient.

24. **Bruck.**—Corrosive sublimate in the treatment of urethritis. *Centralbl. f. d. Med. Wiss.*, July 1st, 1876, p. 481. (*Phil. Med. and Surg. Rep.*, Sept. 9, 1876, p. 212.)

25. **De Vos.**—Alum in urethritis. *Presse Méd. Belge*, Dec. 19, 1875. (*N. Y. Med. Journal*, May, 1876, p. 537.) Saturated solution injected two or three times a day. Most applicable as acute symptoms subside. Author expects rapid cure in all cases.

26. **Dupony, E.**—Kava-Kava in blenorrhagia. *Journal de Thérap.*, No. 4, 1876. (*Rev. des Sci. Méd.*, April 15th, 1876, p. 57.) Infusion of 4 to 5 grammes of root is the daily dose. Cure is expected in 10 to 12 days.

27. **Gamberini, P.**—Blenorrhagic urethrodynia treated by subcutaneous injections of the chlorohydrate of morphia. *Giorn. Ital. d. Mal. Ven. e. d. Pelle. Fascic. I*, 1875. (*An. de Derm. et de Syph.*, Tom. VII., No. 2, p. 144.)

28. **Gatewood, W. K.**—Treatment of gonorrhœa. *Va. Med. Monthly*, April, 1876, p. 12.

29. **Johnson, J. V.**—The rational abortive treatment of gonorrhœa. *Atlanta Med. and Surg. Journal*, March 25, 1876.

30. **Maury, F. F.**—Stages and treatment of gonorrhœa. *Med. and Surg. Reporter*, June 17th, 1876, p. 481.

31. **Muller, F. W.**—Pathology and treatment of gonorrhœa. *Stuttgart*, 1875.

32. **Palmer, E. R.**—Treatment of gonorrhœa in females. *Louisville Med. News*, Jan. 22nd., 1876, p. 138.

33. **Prince, J. P.**—Treatment of gonorrhœa by injections with a reversed current. *Med. Times & Gaz.*, Oct. 23rd., 1875. (*Practitioner*, Dec. 1875, p. 443.)

34. **Ricord.**—Camphorated opiate injection for blennorrhagia. *Le Prog. Méd.* Nov. 6th., 1875, p. 655.

35. **Rollet.**—Anti-blennorrhagic injections, *Le Prog. Méd.* Nov. 5th., 1875, p. 655.

36. **Starke, G. A.**—Use of oleum erigerantis Canadensis in treatment of gonorrhœa. *Canada Med. & Surg. Jour.* May. 1876. (*Half Yearly Comp.* July, 1876, p. 467.)

37. **Vogel.**—On the mechanism of infection in gonorrhœa *Centralbl. f. chir.* 1875, No. 42. (*Rundschau* June, 1876, p. 507.)

38. —Gonorrhœa &c., *Bellevue Hosp. Rep. N.Y. Med. Record*, Oct. 2nd., 1875, p. 662.

BRUCK (24.) cures (?) urethritis with minute doses of bichloride of mercury by the mouth continued for six weeks.

39. **Chiene, John.**—Note on the treatment of gleet. *Med. Times & Gaz.*, June 24th., 1876, p. 686.

40. **Grunfeld, J.**—Auto-endoscopy of the urethra. *Allg. Wien. Med. Zeit.* (*Rundschau*, July, 1876, p. 566.)

41. **Grunfeld.**—On the detection and treatment of stricture of the urethra by the endoscope. *Wien. Med. Wochenschr.*, Sept 11th. 1875.

42. **Grunfeld.**—On the use of the endoscope. *Vrtlsschrft f. Derm. u Syph.*, 1874, 2 & 3 p. 341.

43. **Otis, T. N.**—Stricture as initial cause of gleet with remarks on the urethral calibre. *N. Y. Med. Journ.* April 1876. p. 337.

44. **Sands, H. B.**—On the cause of gleet, and on the calibre of the male urethra. *N. Y. County Med. Soc; N. Y. Med. Record*, Feb. 5th., 1876, p. 93; *N. Y. Med. Journ.* March, 1876; Discussion on paper, *N. Y. Med. Record*, March 11th., 1876.

45. **Stewer, J. A.**—On endoscopy and a new endoscope. *Vierteljahrschrft f. Derm u. Syph.* 1876, p. 39.

46. **Weir, R. F.**—The normal urethra and its constrictions in relation to strictures of large calibre. *N. Y. Med. Journ.* April, 1876, p. 379.

CHIENE (39) praises urethral injections of clay earth mixed into a paste with oil and water in the treatment of gleet. He refers to Godon's papers.

47. **Bardinet.**—Strictures and their treatment by internal massage. *L'Union Méd.* (*Memorabilien*, July 21st., 1876, p. 234.)

48. **Brinton, J. H.**—Urethral stricture. *Med. & Surg. Reporter*, Jan. 15th., 1876, p. 45.

49. **Cobb, W. H. H.**—Stricture of the urethra treated with laminaria digitata bougies. *Va. Med. Monthly*, Aug. 1876, p. 372.

50. **Dora, J. W.**—Stricture of the urethra. Supra pubic tapping with aspiration of the bladder twenty-seven times within ten days. *Med. & Surg. Reporter*, Feb. 12th; 1876.

The patient died by the kidney disease. Punctures did not hasten the issue.

51. **Dubuc.**—On the value of tying in the sound in the treatment of certain strictures of the urethra. *Gaz. des. Hôp.* 12 Feb. 18 & 25 March, 1876.

One excellent case with remarks.

52. **Duplay.**—Stricture of the urethra. *Le Prog. Méd.*, p. 565, Aug. 5, 1876.

53. **Giberson, C. H.**—New instrument for the treatment of strictures of the urethra, with cases. *Proceedings of the Med. Soc. of the County of Kings, N. Y.*, June 1876, p. 93.

54. **Hill, Berkeley.**—Treatment of incipient stricture by Otis's operation. *Lancet*, April 8, 1876, p. 522. Hill raises objections to the treatment which are answered later by Otis. *Lancet*, June 3rd, and June 10.

55. **Jordan, Furneaux.**—On the retention of bougies instead of catheters for the continuous dilatation of strictures. *Lancet*, Jan. 29, 1876, p. 169. (*Braithwaite*, July 1876, p. 145.)

56. **Langlebert.**—Stricture of urethra, mediate dilatation of. *Gaz. des Hôp.*, Feb. 8th, 1876.

57. **Langlebert.**—Mediate dilatation, a new method of treatment for strictures of the urethral canal. *Lyon Méd.*, Feb. 13th, 1876, p. 254.

58. **Macnamara, Rawdon.**—On strictures of the urethra. *Med. Press and Circular*, Sept. 29th, p. 249. (*Braithwaite*, Jan., 1876, p. 162.)

59. **Maury, F. F.**—Stricture of the urethra. *Med. and Surg. Reporter*, May 27th, 1876, p. 421.

60. **Milne, J. A.**—Dilating urethrotome. *N.Y. Med. Record*, Feb. 19th, 1876, p. 133.

61. **Otis, F. N.**—Explanatory remarks in the treatment of strictures of the urethra and gleet. *Lancet*, June 3rd, p. 808, and June 10th, p. 845. 1876.

62. **Parona, F.**—On the use of laminaria in stricture of the urethra. *Annal. Univ. di Med. Chir.*, July and Aug., 1875. (*Rundschau*, June, 1876, p. 597.)

63. **Richet.**—Stricture of the urethra. (*Soc. Anat.*) *Le Prog. Méd.*, May 6th, 1876, p. 358.

64. **Teevan.**—Stricture of the urethra and scrotal fistula, etc. *West London Hospital. Lancet*, Feb. 19th, 1876, p. 279.

65. **Teevan.**—On the choice of an operation for stricture of the urethra. *Med. Times and Gaz.*, April 1st, 1876.

66. **Thompson, Sir Henry.**—On stricture, etc. *Lancet*, Nov. 27, Dec. 4, Dec. 11, Dec. 18, 1875. Jan. 1, Jan. 8, 1876. (Braithwaite, July, 1876.)

67. **Ultzmann.**—Treatment of urethral stricture. *Wiener Med. Press*, 1875.

68. **Van Holsbeek.**—Traumatic strictures of the urethra and their treatment. *La France Méd.*, Aug. 14th, 1875, p. 525.

69. **Wagstaff.**—Obstinate stricture treated by potassa fusa. *Med. Times and Gaz.*, Oct. 9th, 1875, p. 421.

70. **Wallace, T. C.**—Nelaton's catheter in stricture of the urethra, enlarged prostate, etc. *Am. Jour. of Med. Sci.*, April, 1876, p. 416.

71. **Watson, P. H.**—New urethrotome for internal urethrotomy. *Lancet*, Oct. 22, 1875, p. 585. (Braithwaite, Jan., 1876, p. 154).

72. **Weston, E. B.**—Stricture of the urethra. *Detroit Rev. of Med. and Phar.*, March, 1876, p. 143.

73. **Wilson, M. A.**—Divulsion of urethral stricture, copious. hæmorrhage at the end of a week. *N. Y. Med. Record*, Jan. 29th, 1876, p. 67.

LANGLEBERT'S mediate dilatation, (57, 58,) is performed by means of two instruments—an olivary conical bougie, split on both sides, and a whalebone straight instrument with an oval bulb. There are of course different sizes of each instrument; the bougie is introduced and the whalebone bulb pushed down inside of it. L. claims that it gives but little pain and cannot make a false passage.

74. **Bermingham, E. J.**—Recto-urethral fistula. *N. Y., Med. Journ.*, Feb., 1876, p. 113.

75. **Coulson, Walter.**—Case of perineal section, followed by the operation of Dr. Otis for the cure of fistula in the perineum. *Lancet*. Aug., 1875, p. 304. (Braithwaite, Jan., 1876, p. 159.)

76. **Fourestie, H.**—Gonorrhœal rheumatism, *Gaz. Méd. de Paris*, 27, 28, 32, 33, 1875, (*N. Y. Med. Record*, Oct. 16th, 1875, p. 694.)

77. **Geddings, J. F.M.**—Nature and treatment of gonorrhœal rheumatism. *Charleston Med. Journ. and Rev.*, April, 1876.

78. **Gries, C. P.P.**—Gonorrhœal rheumatism. *Thèse de Paris*, p. 72, *La France Méd.*, Jan. 12th, 1876, p. 30.

79. **Hirschberg, J.**—Treatment of gonorrhœal conjunctivitis, *Berl. Klin., Woch.*, 1875, p. 135.

80. **Hutchinson, James H.**—Pyemia following gonorrhœa in a female patient. *Med. & Surg. Reporter*, Feb. 5th, 1876, p. 105.

81. **Maymon.**—Tendinous blennorrhagic synovitis. *Archiv. Gén. de Méd.*, Nov., p. 555, and Dec., p. 653, 1875, (*Rev. des Sci. Méd.* 1876, p. 237.)

82. **Murchison.**—Two fatal cases of acute pyelitis and nephritis, apparently consequent on gonorrhœa. *Med. Times and Gaz.*, Dec. 11th, 1875. *Brit. Med. Journ.*, Dec. 4th, 1875, p. 670.

83. Ricord.—Treatment of complications of gonorrhœa. *La France Méd.*, No 90, 1875. (*Practitioner*, Oct., 1875, p. 297.)

84. Taylor, Ch. Bell.—Remarks on gonorrhœal ophthalmia. *Med. Times and Gaz.*, April 1st, 1876.

—Urethro-rectal fistula, caused by forcible introduction of sounds. Recovery after perineal section and rectal (silver) suture. *N. Y. Med. Record*, Jan. 8th, 1876, p. 18.

BERMINGHAM (74) effected a rapid cure of a recto-urethral fistula by three applications of fused nitrate of silver on a probe, by the aid of a rectal speculum and divulsion of the anal sphincter. The bowels were kept quiet for twelve days by opium.

85. Coombs, C. P.—Case of severe orchitis following paracentesis. *Med. Press and Circular*, Feb. 23rd, 1876.

86. De Smet, E.—Note on a case of gonorrhœal orchitis, the diseased testicle being retained in the inguinal canal. *La Presse Méd.* Belge, June 25th, 1876.

87. Gay, J.—Orchitis. *Lancet*, Feb. 19th, 1876, p. 276.

88. Jordan, Furneaux.—Abstract of a clinical lecture on the extension of inflammation from the epididymis to the urethra. *Med. Times and Gaz.*, March 4th, 1876, p. 246.

89. Knaggs, H. G.—Arnica in orchitis. *Brit Med. Journ.*, July 17th, 1875. (*Edin. Med. Journ.*, Feb., 1876, p. 763.) Cure? effected in a fortnight.

90. Marchand.—Suppurating epididymitis following catheterization. Case with autopsy. *Soc. Anat. Le Prog. Méd.* Jan 1st, 1876, p. 11. (*Lyon Méd.* Feb. 13th, 1876. p. 24.)

91. Munn, T. W.—Puncture of the testis in acute orchitis. *Lancet*, March 25, 1876. (Braithwaite, July, 1876, p. 148.)

92. Rivington Walter.—Acute orchitis. *Lancet*, March 18, 1876, p. 417.

93. Smith, H.—Treatment of acute orchitis by puncture of the testis; with discussion. *Lancet*, Jan. 8th, p. 43; 15th, p. 111; 22nd, p. 152; 29th, p. 191. Feb. 5th, p. 226; 12th, p. 267; 19th, p. 301, 1876.

94. Sturgis, F. R.—Case of gonorrhœal epididymitis occurring before the appearance of the discharge. *N. Y. Med. Record*, Oct. 16th, 1875, p. 691.

95. ———. Gonorrhœa alternating with epididymitis. *Med Chir. Centralblatt*, No. 47. (*Rundschau*, Jan., 1886, p. 73.)

COOMBS (85) reports abscess of testicle following shortly after tapping the tunica vaginalis—almost a dry tap—the testicle at the time of the tapping being large and somewhat tender. C. concludes that the injury to the testicle lighted up orchitis, but the facts hardly prove it. The man was in a pyogenic condition at the time, suffering from boils, abscesses, &c.

JORDAN has a case (88) of traumatic epididymitis followed (as an effect) by urethritis—and another case bearing upon the same possible propagation upwards of an inflammation along the canal of the vas deferens—see Sturgis's case (94) which may have been

of the same character. Jordan alludes also to the possibility of suppuration in the epididymal inflammations of the cachectic.

96. **Auger.**—Spontaneous orchitis terminating by mortification of the testicle without suppuration. *La France Méd.*, May 31st, 1876, p. 277.

97. **Barwell, R.**—Operation for varicocele by the subcutaneous wire loop. *Lancet*, June 12th and 19th, 1876. (*N. Y. Med. Record*, Aug. 14th, 1875, p. 552.)

98. **Boutellier.**—Scrotal phimosis—epispadias. *Le Mouvement Méd.*, Sept. 25, 1875.

99. **Bridson.**—Scrofulous testicle. *N. Y. Path. Soc. N. Y. Med. Record*, Dec. 11th 1875, p. 827.

100. **Duke, M. S.**—Meningitis and orchitis after mumps. *Lancet*, Sept. 25th, 1875, p. 471.

101. **Duplay, M. S.**—Encysted hydrocele of the testicle coincident with an orchiepididymitis. *Le Prog. Méd.*, March 4th, 1876, p. 165.

102. **Malassez.**—Note on the seat and structure of the tuberculous granulations of the testicle. *Arch. de Phys. norm. et path.*, January and Feb., 1876, p. 56.

103. **Marchand.**—Cartilaginous deposits in the tunica vaginalis—concomitant hydrocele. (*Société Anatomique*) *Le Prog. Méd.*, Oct. 23, 1875, p. 68.

104. **Montard, Martin.**—Ablation of a cancerous testicle, &c. (*Société Anatomique.*) *Le Prog. Méd.*, May 20th, 1876, p. 395.

105. **Mulreany, I.**—Gonorrhoeal and syphilitic affections of the testicle. *Med. and Surg. Rep.*, April 18th, 1876, p. 301.

106. **Reclus, P.**—Atrophy of the testicle (*Société Anat.*) *Le Prog. Méd.*, Oct. 23rd, 1875, p. 611.

107. **Stewart, P.**—Supernumerary testicle simulating hernia. *Trans. Mich. State Med. Soc. (Am. Journ. Med. Sci., Jan. 1876, p. 229.)*

108. **Smith, H.**—Strumous disease of the testicle. *Med. So. of London. Lancet*, p. 630, Oct. 30, 1875.

MALASSEZ has published (102) an excellent contribution to the pathological histology of tubercle of the testicle. His conclusions may be condensed as follows :

I. Primitive or elementary granulations. These are comparable to the granulations of serous membranes. They develop in the exterior or serous surface of the seminal tubules. The tubule carrying the granulation is entirely surrounded by it, dilated, its walls and epithelial contents have undergone fatty granular degeneration.

II. Composite granulations—one of the preceding has enlarged and is surrounded by a ring of flattened neighboring tubules, transformed into fibrous cords.

III. Conglomerate granulations—a confluence of several of the preceding granulations. The point of departure, therefore, of all of the different forms of tubercle of the testicle is in the external surface of the seminal tubules. The degeneration of the contents of the tubules is always secondary.

109. **Bassini, S.**—Aspiration of the bladder. *Annali Universali di Med. & Chir.*, July & Aug. 1875.

110. **Gouley, J. W. S.**—Treatment of chronic cystitis. *N. Y. Med. Record*, Oct. 30, 1865, p. 734.

111. **Howe, J. W.**—Cure of cystitis by dilatation of the neck of the bladder. *New York Med. Record*, Aug. 14, 1875, p. 550. The patient was a female.

112. **Jewett, George.**—Rapid dilatation of the female urethra. *Bost. Med. & Surg. Jour.*, Jan. 27, 1876. (*N. Y. Med. Record*, Mch. 11, 1876, p. 173.)

113. **La Garde, L. A.**—A simple method of aspirating the bladder. *N. Y. Med. Record*, Sept. 4, 1875, p. 598.

114. **Skene, A. J. C.**—Urocytic and urethral diseases of women. *N. Y. Med. Record*, Nov. 27, p. 788 & Dec. 4, p. 801, 1875.

115. **Stimson, D. M.**—Broken elastic catheter in the bladder. *N. Y. Path. Soc.*, *N. Y. Med. Record*, Dec. 25, 1875, p. 860.

116. **Tarbell, W. E.**—Injection of strychnine into the bladder for paralysis of that viscus. *N. Y. Med. Record*, Nov. 13, 1875, p. 767. (Female—paralysis came on after labor—lasted three weeks and got well after three vesical injections of strychnine gr. $\frac{1}{8}$; aquæ $\mathfrak{z}$ i. each.)

117. **Teevan.**—Retention and extravasation of urine. *Br. Med. Jour.*, Oct. 1, 1875.

118. **Ultzmann.**—Statistics of vesical calculi. *Wien. Med. Woch.*, Sept. 18, 1875. (*N. Y. Med. Record*, Nov. 13, 1875, p. 760.) This is an account of the physical, chemical &c., characters of eighty-three specimens of vesical calculus belonging to Prof. Dittel.

119. **Wilkins, Geo.**—Extroversion of the bladder, and epispadias. *Canada Med. Record*, March 1875. (*Am. Jour. Med. Sci.*, Oct. 1, 1875, p. 256.)

120. **Ziemssen.**—Vol. IX. Diseases of the urinary organs. Leipzig, 1875.

LA GARDE (113) extemporized an aspirator by evaporating a little chloroform by heat in a bottle, corking the bottle when the vapor had filled it, inserting canula, attaching rubber tube and hypodermic needle—and then producing vacuum in the bottle by condensation of the vapor of chloroform. In this way he successfully removed two pints from the bladder of a teamster.

(Lack of space in the present issue of the *ARCHIVES* makes it impossible to include in this digest abstracts from several long and very valuable papers reported by title. An attempt has been made to economize space by adding a few explanatory words to the title, where it was possible in this way to throw light upon the subject matter of the article. E. L. K.)

Reviews and Book Notices.

Handbook of Skin Diseases. By DR. ISIDOR NEUMANN, Professor of Dermatology and Syphilis in the University of Vienna. (*Lehrbuch der Hautkrankheiten.*) Fourth enlarged edition, with 76 wood cuts. Wien : 1876. pp. 688.

BUT very rarely has it happened in the history of medicine that a work on diseases of the skin has reached a fourth edition, and never, we believe, within the short space of time occupied by this excellent book of Dr. Neumann's in successively passing through its four editions. About seven years from the date of the first issue, the fourth is called for, and is in many respects the most complete as well as the best work on skin diseases extant. While not as exhaustive as Hebra, nor, for the American practitioner, as practical as some other works, it is still to be regarded as leading the way in the study of diseases of the skin.

It will be remembered that Neumann was the first since Simon and Bärensprung to introduce illustrations of microscopic anatomy in a text book on the skin ; and the American translation, in 1872, of the second edition, was the first work, in this country, in the English language, where this feature existed. Dr. Neumann has continued his studies in this direction, and this fourth edition contains several additional plates, and is nearly double the size of the first edition ; and is, moreover, quite as remarkable for the fulness of the foot-note and other references to the labors of others in dermatology as the former editions were noticeably deficient in such allusions.

It is a source of dissatisfaction that so little is said in regard to treatment, and that so few of the indications for various remedies are mentioned ; the treatment advised is mostly the local, and but little attention is paid to constitutional measures, diet, hygiene, etc. We are surprised at the statement that arsenic is of no service in pemphigus, and also at the very slight mention of ergot in the treatment of purpura ; we consider that the successful

employment of these remedies forms about the most striking advance in cutaneous therapeutics during the past decade.

The present edition has an appendix of twenty pages of formulæ, and a good index; it is better arranged than former editions, and altogether is a very attractive and useful compendium of skin diseases.

Books and Pamphlets received, other than those mentioned in the Review and Digest departments.

De l'Eléphantiasis du Scrotum, by Raoul Broquère. Paris. Octave Doin. 1875, pp. 92, with two plates.

De la Dengue (fièvre éruptive des pays chauds) etc., by Albert Morice. Paris, Delahaye, 1875, pp. 62.

De l'Eczéma et du Psoriasis traités par les Eaux d'Uriage, by A. Niepce. Paris, Masson, 1875, pp. 36.

Key to Skin Diseases, etc., by Tilbury Fox, M. D., F. R. C. P. London, Renshaw, 1875, pp. 12.

Report on Vaccination, an Inquiry concerning Human Vaccine, Vaccino-Syphilis and Animal Vaccine, etc., by Dr. Wm. B. Davis. Cincinnati, 1876, pp. 32.

Le Psoriasis herpétique aux Eaux de la Bourboule, by Dr. A. Vérita. Paris, Delahaye, 1876, pp. 20.

A Contribution to the Pathology of Epithelium, by Arthur Van Harlingen—(reprint from Am. Jour. Med. Sci., July, 1876), pp. 8.

Erfahrungen über Syphilis, by Dr. W. Boeck. Stuttgart, Enke, 1875, pp. 282.

Du Rheumatisme Syphilitique, by Adolph Vaffier. Paris, Delahaye, 1875, pp. 84.

Ueberluetische Erkrankungen des Gehirns und Rückenmarks, by C. Wunderlich (Sammlung klinischer Vorträge. Volkmann No. 93) Leipzig, 1875, pp. 22.

Traitement de la Syphilis par les Fumigations de Calomel, by Dr. Horteloup. Paris, Delahaye, 1875, pp. 15.

A contribution to the study of Syphilis of the Nervous System, by R. W. Taylor, M. D. (Reprint from Jour. Nerv. and Ment. Dis., Jan., 1876) pp. 23.

A contribution to the Study of the Transmission of Syphilis, by R. W. Taylor, M. D. (Reprint from Archives of Clin. Surg., Sept., 1876). pp. 15.

Notice sur le Traitement de la Syphilis par les Fumigations de Calomel, etc., by Dr. Horteloup. Paris, Masson, 1876, pp. 15.

(Authors of books, pamphlets, reprints, also of journal articles are requested to forward copies of the same at earliest possible date, to ensure an early notice in the Review and Digest departments. EDITOR.)

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The name of the **JOURNAL** will also be changed by omitting Chicago from its title, thus rendering it cosmopolitan in name as well as in circulation. It will accordingly be known hereafter as the "**JOURNAL OF NERVOUS AND MENTAL DISEASE**." It will also be increased in size, as compared with the former volumes, each number containing from 160 to 200 pages of closely printed matter. Corresponding to its increase in size, the subscription price will be increased to Five Dollars per annum, or One Dollar and Fifty Cents a number.* A number of minor changes will be made in its arrangement, that will not be noticed in this place, but which will all contribute to render it more attractive and useful than before.

The arrangement of matter in the **JOURNAL** will continue to be as in the former volumes, viz.:

I. A Department for Original Articles, which may also contain selections and translations of articles of merit, from a wide range of Foreign Periodicals, on subjects relating to the Nervous System and Mind.

II. A Department for Reviews, in which an attempt will be made to give full and critical surveys of all new and important works and papers which may appear, in regard to the Nervous System or Mind, whether in this country or abroad. Our readers will thus be enabled to obtain the substance of all new works of importance falling within our Department.

III. An Editorial Department. This will be maintained to give place for the discussion of such topics as may appear to call for special notice, and which may not belong to the other departments of the **JOURNAL**.

IV. A Periscope Department. This will comprise from thirty to forty pages of small type, and in it will be found condensations, made for this **JOURNAL**, of a large number of articles from English, German, French, Italian, and other periodicals, the whole arranged under three heads:

1. *Anatomy and Physiology of the Nervous System.*
2. *Pathology of the Nervous System, and Pathological Anatomy.*
3. *Therapeutics of the Nervous System and Mind.*

It is our purpose to give this latter department of the **Periscope** great attention, publishing in it everything that is new in regard to the treatment of nervous and mental diseases. Each number of the **JOURNAL** will contain, besides the matter mentioned, a list of all important new works in the department of Neurological medicine that may appear either at home or abroad.

In every department of the **JOURNAL** no pains will be spared to make it all that could reasonably be desired. But in respect to the first department or that for **ORIGINAL COMMUNICATIONS**, we are gratified in being able to announce to our readers, that we shall henceforth be able to present them with articles from a large number of the most eminent members of the profession in this country. This department of the **JOURNAL** is to be enlarged, and promises to be not inferior to that of any other **JOURNAL** in the country in point of freshness and excellence. The department for **REVIEWS** is to receive increased attention, while the **PERISCOPE** will fairly and fully reflect the progress of Neurological Science in all parts of the world.

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Subscriptions and all business connected with the **JOURNAL** may be addressed either to the editors, at 57 Washington Street, Chicago, or to the Eastern publishers, G. P. Putnam's Sons, 308 Fourth Avenue, New York.

Respectfully,

J. S. JEWELL, M. D. } Editors.
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